PRINTED: 10/06/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 095034 09/19/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE CARROLL MANOR NURSING & REHAB WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CROSS-SUMMARY STATEMENT OF DEFICIENCIES (XB) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX MPLETION DATE PRÉFIX TAG OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY F 000 INITIAL COMMENTS F 000 An annual certification survey was conducted from September 15 through 19, 2008. The following deficiencies were based on observations, staff and resident interview and record review. The sample size was 30 residents based on a census of 242 the first day of survey. The sample also included nine (9) supplemental residents. 483.10(c)(7) ASSURANCE OF FINANCIAL F 161 F 161 483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY SS=B SECURITY 1. The Surety Bond for the Resident Trust The facility must purchase a surety bond, or Fund was increased from \$275,000 to otherwise provide assurance satisfactory to the \$375,000. 9/17/08 Secretary, to assure the security of all personal 2.All residents with a Trust Fund account will be protected by the increase of the amount of funds of residents deposited with the facility. the Surety Bond. 3.On a monthly basis, the Trust Fund bank statements will be reviewed for the daily This REQUIREMENT is not met as evidenced by: balance and not the beginning and ending balances to ensure the Surety Bond is in Based on record review and staff interview, it was excess of the amount in the bank. The determined that facility staff failed to provide surety Trust Fund bank statements will be bond coverage to assure the security of all funds in

The findings include:

the residents' account.

A review of the surety bond on September 15, 2008 at 12:01 PM indicated the surety bond held by the facility was in the amount of \$275,000.00.

A review of bank statements for the past three (3) months indicated that on July 31, 2008 the balance in the resident fund account was \$315, 000.00.

A face-to-face interview was conducted with Employee #9 on September 15, 2008 at 12:05 PM. Employee #9 stated: "that this only

reviewed by the Business Office Manager as well as the Finance Department for compliance. Upon review of the statements, a report will be given to the Administrator starting with the September 2008 statements and

4. A quarterly report summarizing compliance And corrective action, if needed, will be Prepared for the Quarterly QI Committee.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XB) DATE

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.

Event ID: VOMI11

Facility ID: CARROLLMANO

Mannedata

monthly thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/1	9/2008
	OVIDER OR SUPPLIÉR	REHAB	7	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 161	Continued From pag		F 161			
	happened because subsequent interview 2008 at 9:15 AM and he/she understood t bond would be incre	t was a weekend". A w was held on September 17, d Employee #9 stated that he regulation and the surety ased.				
F 164 SS=D		e right to personal privacy and	F 164	1. Resident's privacy was mainta all future dressing changes for R	ined for	9/17/08
	confidentiality of his records.	or her personal and clinical		# 8.2. Dressing change policy was rewith all staff to ensure that privace		10/3/08
	medical treatment, v communications, pe meetings of family a	ludes accommodations, vritten and telephone rsonal care, visits, and nd resident groups, but this		be maintained during dressing ch 3. Wound care nurse will conduct random competencies on license 4. Results will be submitted to Di	t monthly ed staff.	10/2/08 10/9/08
	does not require the room for each reside	facility to provide a private ent.		Nursing for presentation to quarte Committee for review.	erly QI	
	section, the resident	n paragraph (e) (3) of this may approve or refuse the and clinical records to any e facility.				
	and clinical records resident is transferre	o refuse release of personal does not apply when the ed to another health care release is required by law.				
	contained in the resi the form or storage r is required by transfe	ep confidential all information dent's records, regardless of methods, except when release er to another healthcare party payment contract; or the				
	This REQUIREMEN	T is not met as evidenced by:			•	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE NASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETION DATE
F 167 SS=C	Based on observation dressing changes, it staff failed to provid change for Residen The findings include On September 14, 2 #15 was observed at to Resident #8's right Employee #15 faile and pull the privacy change. Resident #During the dressing the room to assist the change and the document of the provident of the state of the provident of the state of the provident of the pro	t was determined that facility to e privacy during a dressing to #8. 2008 at 11:32 AM, Employee administering a dressing change in the and right 5th toe. d to close the resident's door curtain prior to the dressing resides in a semiprivate room. Change, Employee #5 entered in a nurse with the dressing in and privacy curtain remained. INATION OF SURVEY ight to examine the results of the of the facility conducted by veyors and any plan of with respect to the facility. Ike the results available for list post in a place readily into and must post a notice of into and staff interview, it was one and staff interview, it was	F 164	483.10(g) (1) EXAMINATION RESULTS 1. The Survey notebook was rack at the front desk. It was ledge in front of the Front De Receptionist when brought to employee's attention. 2. The employee checked the rights boards on each unit are the survey results notice post 1, 2, 3, 4, 5 & 6. 3. The front desk Receptionist document the presence of the notebook in the Receptionist each shift. 4. The Communication Manamonitor the documentation as a monthly report for the Administration.	is located in a splaced on the splaced on the sek of the eresidents and found steed in units st will see survey alog book on ager will and prepare inistrator, as the facility	9/18/08 9/18/08 10/1/08
	determined that faci	lity staff failed to make the able for examination and				

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	ROVIDER OR SUPPLIER	REHAB	s	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
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F 167	of their availability. The findings include Observations made September 15-18, 2 (3) resident units, fa survey results or nor results could be loca On September 18, 2 face-to-face intervie who acknowledged posted in the identific	by the survey team from 008 of the lobby area and three iled to reveal the location of tices identifying where survey ated. 2008 at approximately 7:30 PM a w was held with Employee #1 that the survey results were not ed location. He/she stated that osted indicating the location of	F 16	7		
F 225 SS=D	been found guilty of mistreating residents a finding entered introducerning abuse, residents or misapport any knowledg law against an emplunfitness for service staff to the State nurauthorities. The facility must ensinvolving mistreatme injuries of unknown resident property are	employ individuals who have abusing, neglecting, or so by a court of law; or have had to the State nurse aide registry reglect, mistreatment of ropriation of their property; and re it has of actions by a court of royee, which would indicate as a nurse aide or other facility re aide registry or licensing resure that all alleged violations and the reported immediately to the facility and to other officials in	F 22	TREATMENT OF RESIDENT 1. Resident # 4- Bruised are back has resolved. Currently # 4 has no bruises. 2. All residents will be asses discoloration and for those is investigative reports will be submitted to the Department 3. Unit management to moni incidence of skin discoloration investigation and report to wonurse for tracking. 4. Results will be submitted to f Nursing for presentation in QI Committee Meeting.	a to upper resident sed for skin dentified, an done and of Health. tor daily new on, initiate an ound care	10/8/08 10/8/08 10/8/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017				
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F 225	State survey and ce	procedures (including to the rtification agency). re evidence that all alleged ghly investigated, and must	F:	225		٠,	
	The results of all investigation is in protection of the administrator or and to other officials (including to the Statagency) within 5 wor	estigations must be reported to his designated representative in accordance with State law te survey and certification king days of the incident, and if is verified appropriate					
	Based on observation review for one (1) of determined that facily investigation for Resunknown origin. The findings include: A review of Resident following nurses' not	t #4's record revealed the es:					
	August 11, 2008 at 2 reported purplish dis upper back region. Na signs or symptoms of A face-to-face intervise September 19, 2008	2055 (8:55 PM): "Charge nurse coloration on resident's right lo hematoma observed. No if pain" iew was conducted on at 10:30 AM with Employee We looked at the way (Resident					

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		095034	B. WIN	G	· ·	09/1	9/2008
	OVIDER OR SUPPLIER	REHAB		725	ET ADDRESS, CITY, STATE, ZIP CODE BUCHANAN ST., NE ASHINGTON, DC 20017		
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F 225	bumping into walls. [he/she] sat in all ov determine where the with (Resident #4) to that the metal arm was resident right in the We think that may he bruise. I am going to that bar." There was no evident the cause of Reside Employee #3 ackno complete the investion.	We looked at the chairs er the unit. We couldn't e bruises came from. I walked to [his/her] bathroom and saw was pulled down. It hit the same spot that the bruise was ave been what caused the to ask Physical Therapy to pad the one that the investigation into the manner of the truises was completed will will be to gation. The record was	F	225			
F 226	The facility must developed policies and procedure neglect, and abuse misappropriation of this REQUIREMENT Based on review of interview, it was detected to implement a policity residents during allest The findings included A review of the facility Neglect Investigation "Employees who has abuse may be reass"	relop and implement written ures that prohibit mistreatment, of residents and resident property. T is not met as evidenced by: the facility's policy and staff ermined that facility staff failed y that affords protection to all ged abuse investigations. : ty's Policy No.: 2003.1 "Abuse & n" revealed, we been accused of resident igned to nonresident duties or y, until the Administrator	F	1 2 a 3 s a e u a b s s A	A83.13(c) STAFF TREATMENT RESIDENTS 1. No specific resident identified 2. Currently there are no alleged a allegations against any staff mem 3. The practice has been to suspense the staff member who has been accused any resident abuse until the allegabither been substantiated or unsubstantiated. The policy will be amended to read "Employees who been accused of resident abuse we suspended from duty, until the Administrator reviews the results of the Normal Services Manager will report immediately any discreptor the Administrator and appropriation of the Admi	abuse ber. end a sed of ation has e have vill be vill ace and pancies	10/28/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
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	OVIDER OR SUPPLIER	& REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
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F 226		view held on September 19,	F2	226		1	
	been here, staffs wunits."	d, "In the four (4) years I have vere usually re-assigned to other owledged that staff were re-					
	assigned to other of during an alleged a	care areas [within the facility] abuse investigation in a face-to- ducted on September 19, 2008 at					
	evidence that it pro	ect Investigation policy lacks vides protection to all residents ation of alleged abuse.					
F 241 SS=D	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in full	F2	241	483.15(a) DIGNITY 1. Resident JH4's dignity was ac with staff and staff will knock prientering the room. 2. Staff was inserviced on reside and will knock on all residents designed.	or to ents dignity	9/15/08
	Based on observat	NT is not met as evidenced by:			to entering. 3. Unit management will monitor on unit for compliance. 4. Any incidence of non-complia	r staff on	10/8/08
	was determined the on Resident JH4's	or one (1) of eight (8) residents, it at the facility staff failed to knock door before entering the room.			reported to Director of Nursing to quarterly QI Committee for revie		On-going
	during the morning	2008 at approximately 10:30 AM medication pass, Employee #25 f Resident JH4 without knocking					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	IG		09/1	9/2008
	OVIDER OR SUPPLIER	REHAB	•	72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017	·	
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F 241	Continued From page	ge 7	F	241			
	September 15, 2008 Employee #25. Emp	riew was conducted on 3 at approximately 3:30 PM with bloyee #25 acknowledged that k on the resident's door prior to					
F 253	483.15(h) (2) HOUS	EKEEPING/MAINTENANCE	F	253			
SS=E	maintenance service	ovide housekeeping and es necessary to maintain a d comfortable interior.	·				
	This REQUIREMEN	IT is not met as evidenced by:					
	the environmental to 2008 from 8:45 AM September 16, 2008 through 1:30 PM, it failed to provide how services necessary homelike environme by: soiled/damaged doors, walls, basebo bathroom doors, fun Ventilation and Air Oblinds, window screedoors, call bells, coulinen carts; caulking bathrooms; dusty be surfaces, bathroom window sills, and da These observations	ons and staff interview during our conducted on September 15, through 9:00 PM and 3 conducted from 8:45 AM was determined that the facility askeeping and maintenance to maintain a safe, clean, and ent for residents as evidenced floors, wall paper borders, oards, exhaust vents, accordion niture, HVAC (Heating, Conditioning) units, ceiling tiles, ens, thresholds to bathroom anter tops, sprinkler heads and damaged on backsplash in ed frames, top of closet lamps, shelf over the bed, maged/soiled toilet seats. were made in the presence of , 6, 7, 8, 23, 26 and 27.					
	The findings include	<i>,</i>					
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION 'G	(X3) DATE SURVEY COMPLETED/	
		095034	B. WING _		09/19/2008	
	ROVIDER OR SUPPLIER L MANOR NURSING &	REHAB		REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	33/13/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETION	
F 253	1.13 of 64 floors were follows: 1st floor rooms: 125 2nd floor rooms: 207 3rd floor rooms: 342 Rehabilitation toilet of 4th floor rooms: 405 5 East room: 562. 2.12 of 64 wall paped damaged/marred as 1st floor rooms: 103 2nd floor rooms: 347 4th floor rooms: 405 5th floor rooms: 502 3. 32 of 64 doors were as follows: 1st floor rooms: 103 153 and 156. 2nd floor rooms: 207 storage and soiled us 3rd floor rooms: 301 4th floor rooms: 301 4th floor rooms: 502 room. 5 East room: 560. 4. 28 of 64 rooms were marred/scarred/dam 1st floor rooms: 107 utility room, bathing 2nd floor rooms: 202 storage room, and a 3rd floor rooms: 314	re observed damaged/soiled as 1, 131, 136 and 156. 7, Activity room. 9, staff bathroom and room. 9, 424 and 426. The borders were observed follows: 107, 136, 153 and 156. and 354. and 454. and 530. The observed marred/worn/soiled follows: 107, 115, 124, 130, 131, 141, 147, 147, 148, 148, 148, 148, 148, 148, 148, 148	F 25	1.) 483.15(h) (2) HOUSEKEEPIN MAINTENANCE 1. An outside contractor was notified and/or replace floors. 2. All other floors were inspected an repairs and replacement will be doroutside contractor. 3. Monitor the floors and take correction when needed. 4. Report monitoring results and contractions to the QA committee quarter ordered and will be replaced up of the new borders. 2.) 483.15(h) (2) HOUSEKEEPIN MAINTENANCE 1. The wallpaper borders have a longer to the new borders. 2. All other wall paper borders will be replaced as a monitor the wallpaper border corrective action when needed. 4. Report monitoring results an actions to the QA committee quarter ordered and will be replaced as a mactions to the QA committee quarter ordered. 3.) 483.15(h) (2) HOUSEKEEPIN MAINTENANCE 1. The doors were cleaned and 2. All doors were inspected and 2. All doors were inspected and 3. Monitor the doors and take corrective action when needed. 4. Report monitoring results and actions to the QA committee quarter ordered. 3. Monitor the doors and take corrective action when needed. 4. Report monitoring results and actions to the QA committee quarter ordered.	and to repair and identified. The by an an active orrective or rective on receipt on receipt were as needed. The sand take of arterly. NG I restained of will be a corrective on 10/6/08 of corrective on 10/6/08 of corrective or on 10/6/08 of corrective of the sand take of corrective or on 10/6/08 of corrective of the sand take of corrective of the sand take of	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 253	room and day room. 5th floor rooms: 505 5 East room: Clean 5. 20 of 64 rooms we soiled/damaged cov 1st floor rooms: 107 utility room and pant 2nd floor rooms: 324 Rehabilitation room. 4th floor rooms: 405 5th floor rooms: 523 6. 12 of 64 exhaust of follows: 1st floor rooms: 112 room, and soiled util 2nd floor rooms: 202 3rd floor rooms: 301. 4th floor rooms 405 5th floor: staff bathrooms: 120 damaged/staffoor rooms: 112 2nd floor rooms: 245 3rd floor rooms: 301 4th floor rooms: 301 4th floor rooms: 301 4th floor rooms: 301 4th floor rooms: 523	, 546 and 530. utility room. ere observed with e base as follows: , 126, 131, 141, 153, 156, soiled ry. , 326, 342, 354 and , 454 and bathing room. , 530, and staff bathroom. vents were observed soiled as 131, 153, laundry, bathing ity. 2 and 241. and 454. born. In bathroom doors were soiled as follows: , 136, 153 and 156. 5 and 253. , 316, 326 and 354. and 454	F 253	4.) 483.15(h) (2) HOUSEKEER MAINTENANCE 1. The walls are scheduled to be 2. All walls were inspected on 10 Will be repaired as needed. 3. Monitor the walls and take corrective action when needed. 4. Report monitoring results and actions to the QA committee qua 5.) 483.15(h) (2) HOUSEKEER MAINTENANCE 1. The soil and damaged cove be cleaned and repaired. 2 All other cove bases were inspected. 3. Monitor the cove bases and taxorrective action when needed. 4. Report monitoring results and actions to the QA committee qual 6.) 483.15(h) (2) HOUSEKEER MAINTENANCE 1. Vents in rooms identified on #6 cleaned and power washed. 2. Inspect remaining rooms and reclean as needed. 3 Monitor the vents in the rooms corrective action as needed. 4 Report monitoring results and actions to the QI committee quart 7.) 483.15(h) (2) HOUSEKEER MAINTENANCE 1. Rooms identified in #7 have be	corrective rterly. PING asses will be pected on ired as aske corrective rterly. PING b have been epair and and take corrective rerly. PING b have been epair and and take corrective rerly.	11/3/08 11/3/08 On-going 11/3/08 On-going 11/03/08
	1st floor rooms: 107, 2nd floor rooms: 228 4th floor rooms: 405 5th floor room: 546.	, 112, 130, and day room. 3, 241, and day room. , 410, 416, and 445. d a geri chair stored in tub		and cleaned. 2Inspect remaining rooms and reclean as needed. 3. Monitor the accordion bathrootake corrective action when need 4. Report monitoring results and actions to the QA committee quantity.	epair and m doors and ed. corrective	On-going

F 253 Continued From page 10 9. 22 of 64 HVAC units were observed soiled/damaged as follows: 1st floor rooms: 130, 131 and 156. 2nd floor rooms: 202, 207, 213, 231, 245, 253 and 254. 3rd floor rooms: 405, 410, 424, 443 and day room. 5th floor rooms: 510 and 530. 10. 14 of 64 rooms observed with soiled/damaged ceiling tiles as follows: 1st floor rooms: Rest room and soiled utility room. 2nd floor rooms: 335 and Rehabilitation room. 4th floor rooms: 335 and Rehabilitation room. 4th floor rooms: Soiled utility room, 5 East room: 560. 11. 11 of 64 rooms observed with soiled/damaged window blinds as follows: 1st floor rooms: Soiled utility room, and activity room. 5 East room: 560. 11. 11 of 64 rooms observed with soiled/damaged window blinds as follows: 1st floor rooms: Soiled utility room and activity room. 5 East room: 560. 11. 11 of 64 rooms observed with soiled/damaged window blinds as follows: 1st floor rooms: 228, 245, activity room, end of hall by 254 and beauty shop. 3rd floor rooms: 228, 245, activity room, and soiled tility room, and replaced, as needed. 3. Monitor the LPAC units were langeted and repaired. 2. All other Cutils were inspected, cleaned and repaired as needed. 3. Monitor the UAC units and take corrective action when needed. 4. Report monitoring results and corrective action when needed. 3. Monitor the UAC units were langeted. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the UAC units and take corrective action when needed. 3. Monitor the ceiling tiles were inspected and replaced. 3. Monitor the ceiling tiles w			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE MSHINGTON, DC 20017			095034	B. WING	· ·	09/1	9/2008
FREFIX TAG FAITH TAG FAITH TAG FREFIX TAG FREFIX TAG FAITH TAG FAITH TAG FREFIX TAG FREFIX TAG FAITH TAG FREFIX TAG			REHAB	s	725 BUCHANAN ST., NE		<u> </u>
8.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE 1. The furniture were inspected and will be repaired as needed. 3. Monitor the furniture and take corrective actions to the QA committee quarterly. 11/3/08 11/3/0	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	(X5) COMPLETION DATE
	F 253	9. 22 of 64 HVAC ur soiled/damaged as f 1st floor rooms: 130 2nd floor rooms: 202 254. 3rd floor rooms: 301 4th floor rooms: 405 5th floor rooms: 510 10. 14 of 64 rooms ceiling tiles as follow 1st floor rooms: Soi hallway by 245. 3rd floor rooms: 335 4th floor rooms: 426 room and activity roo 5th floor rooms: Soil room. 5 East room: 560. 11. 11 of 64 rooms cowindow blinds as foll 1st floor rooms: 326 254 and beauty s 3rd floor rooms: 301 4th floor rooms: 301 4th floor room: 510. 12. Two (2) of 64 rood damaged window so and 502.	nits were observed collows: 131 and 156. 2, 207, 213, 231, 245, 253 and 342. 410, 424, 443 and day room. and 530. Observed with soiled/damaged is: t room and soiled utility room. led linen, soiled utility and and Rehabilitation room. In clean utility room, bathing om. In the distribution of the distribution of the linen, soiled utility and and Rehability and and Rehability room, bathing om. In the distribution of the linen, soiled damaged lows: In the linen, soiled lows: In the lows: In the linen, soiled lows: In the lows: In the linen, soiled lows: In the linen, soiled lows: In the lows: In the linen, soiled lows: In the linen, soiled lows:	F 25	8.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. The furniture will be repaired in 2. All other furniture were inspected be repaired as needed. 3. Monitor the furniture and take corrective action when needed. 4. Report monitoring results and contact actions to the QA committee quart. 9.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. The HVAC units were cleaned 2. All other HVAC units were inspendent repaired as needed. 3. Monitor the HVAC units and take corrective action when needed. 4. Report monitoring results and contact actions to the QA committee quart. 10.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. The soiled/damaged ceiling tiles replaced. 2. All other ceiling tiles were inspendent as needed. 3. Monitor the ceiling tiles and take corrective action when needed. 4. Report monitoring results and contact action when needed. 4. Report monitoring results and contact action when needed. 4. Report monitoring results and contact action when needed.	its entirety. ed and will corrective erly. NG and repaired. ected, cleaned corrective erly. PING awere cted and e	9/22/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>		
		095034	B. WING		09/19/2008	
	ROVIDER OR SUPPLIER L MANOR NURSING 8	REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 253	2nd floor room: 253 5th floor room: 532 14. Three (3) of 64 if functional but dama 130 and 153. 15. One (1) of one (floor damaged lamir One (1) of one (1) or room. 16. Nine (9) of 14 stractural accumulated debris 1st floor rooms: one three (3) of three (3) 3rd floor room: Two Rehabilitation room. 5th floor room: Two room. 5 East room: One (1) 17. Five (5) of 10 ye observed soiled on in the 2nd floor, 3rd rooms. 18. 13 of 64 rooms above sink with damareas: 1st floor rooms: 131 2nd floor rooms: 220 employee rest room 3rd floor room: 445. 5th floor rooms: 510 toilet in activity room	rooms were observed with ged call bells as follows: 124, 1)) worktable in hallway on 1st nate by room 112. The pounter top in 4th floor activity or inkler heads observed with as follows: (1) of two (2) in pantry and in dining room, (2) of four (4) in the (2) of four (4) in the activity) of one (1) in 562. Illow linen transport carts were the interior and exterior surfaces floor and 4th floor laundry Observed with back splash area naged caulking in the following and rest room. 3, 245, 253, bathing room and loyee rest room.	F 253	11.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. Removed blinds in windows ident 2. Inspect remaining window blinds as needed. 3. Monitor condition of blinds and ta correction actions when needed. 4. Report monitoring results and co actions to the QA committee quarter 12.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1 The window screens were replace 2. All window screens were inspected Replaced as needed. 3. Monitor the window screens and corrective action when needed. 4. Report monitoring results and co actions to the QA committee quarter 13.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. An outside contractor was notified all thresholds 2. All other thresholds were inspected be replaced as needed. 3. Monitor the condition of the threst take correction actions when needed 4. Report monitoring results and co actions to the QA committee quarter 14.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. The call bells were repaired. 2. All other call bells were inspected and repaired. 3. Monitor the condition of the call be take correction actions needed. 4. Report monitoring results and conditions to the QA committee quarter 14.) 483.15(h) (2) HOUSEKEEPI MAINTENANCE 1. The call bells were inspected and repaired. 3. Monitor the condition of the call betake correction actions needed. 4. Report monitoring results and conditions to the QA committee quarter 15.	ified in #11. and clean ake rrective rly. NG d. ad and take rrective rrective d and will hold and d. rrective rly. NG d on 9/16 bells and rrective	9/23/08 9/23/08 On-going 11/3/08 11/3/083. On-going 9/17/08 9/17/08 On-going

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095034	B. WIN	G		09/1	9/2008
	ROVIDER OR SUPPLIER L MANOR NURSING &	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 253 F 278 SS=D	frames as follows: 1st floor rooms: 107 2nd floor rooms: 228 3rd floor room: 342. 4th floor room: 510. 5 East rooms: 560 a 20. Seven (7) of 64 rtop surface of the cld 1st floor rooms: 107 2nd floor rooms: 213 4th floor rooms: 405. 21. Seven (7) of 64 rtights in the bathroor 1st floor rooms: 126 2nd floor rooms: 202 3rd floor room: 454. These findings were cited employees at the 483.20(g) - (j) RESID The assessment mure resident's status. A registered nurse massessment with the health professionals A registered nurse massessment is comp	and 245. A 124, 126, 136 and 156. A 124 and 426. Tooms were observed with the oset dusty as follows: A 130 and 153. A 228 and 254. Tooms were observed with dusty in as follows: and bathing room. A 228 and 254. Tooms were observed with dusty in as follows: and bathing room. A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with dusty in as follows: A 228 and 254. Tooms were observed with the above in the dusty in as follows: A 228 and 254. Tooms were observed with the above in the dusty in as follows: A 228 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dusty in a 258 and 254. Tooms were observed with dust		253	15.) 483.15(h) (2) HOUSEKEEPIL MAINTENANCE 1. The laminate material was ordered replace the worktable. 2. All other worktables were inspective repaired as needed. 3. Monitor the worktables and take corrective action when needed. 4. Report monitoring results and conactions to the QA committee quarter MAINTENANCE 1. The sprinkler heads were cleaned. 3. Monitor the sprinkler heads were inspected. 4. Report monitoring results and to corrective action when needed. 4. Report monitoring results and conactions to the QA committee quarter. 17.) 483.15(h) (2) HOUSEKEEPIL MAINTENANCE 1. The carts were cleaned and sanitications to the QA committee quarter. 17.) 483.15(h) (2) HOUSEKEEPIL MAINTENANCE 1. The Personal Laundry Aide was in on proper cleaning & sanitizing. 3. Monitor the carts and take corrective action when needed. 4. Report monitoring results and conactions to the QA committee quarter. 18.) 483.15(h) (2) HOUSEKEEPIL MAINTENANCE 1. Back splash was ordered and will repaired/replaced upon arrival of ma. 2. All back splash was inspected on and will be repaired/replaced accord. 3. Monitor the back splash and take corrective action when needed. 4. Report monitoring results and conactions to the QA committee quarter. 3. Monitor the back splash and take corrective action when needed. 4. Report monitoring results and conactions to the QA committee quarter.	rrective ly. NG d of debris. d and ake rrective ly. NG ized. inserviced rrective ly. be terials. 10/16 lingly.	10/13/08 11/3/08 On-going 10/13/08 10/13/08 11/3/08 On-going 9/19/08 9/19/08 11/308 On-going 11/3/08 11/3/08 11/3/08 11/3/08 11/3/08 On-going

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095034	B. WING _		09/19)/2008
	OVIDER OR SUPPLIER	3 REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 278	Under Medicare an willfully and knowin statement in a residuivil money penalty each assessment; of knowingly causes a material and false sassessment is subjections.	ge 13 d Medicaid, an individual who gly certifies a material and false lent assessment is subject to a of not more than \$1,000 for or an individual who willfully and inother individual to certify a statement in a resident ect to a civil money penalty of 00 for each assessment.	F 278	 19.) 483.15(h) (2) HOUSEKEEP MAINTENANCE 1. Dusty bed frames identified in #1 cleaned. 2. Inspect remaining rooms and coneeded. 3. Monitor condition of bed frames corrective action as needed. 4. Report monitoring results and contents. 	9 have been clean as s and take corrective	11/03/08
	Clinical disagreeme and false statement	ent does not constitute a material		20. 483.15(h) (2) HOUSEKEEPIN MAINTENANCE 1. Rooms identified with dusty close #20 have been cleaned. 2. Inspect remaining rooms and coneeded.	NG ets (top) in clean as	11/03/08
	(1) of 30 sampled refacility staff failed to Data Set (MDS) ass. The findings include A review of Resider physician's order data.	nt #4's record revealed an initial ated May 1, 2008 and renewed		 Monitor condition of closets an corrective action as needed. Report monitoring results and cactions to the QI committee quarter 483.15(h) (2) HOUSEKEEPIN MAINTENANCE Rooms identified with dusty lightave been cleaned. Inspect remaining rooms and needed. 	corrective ly. IG hts in #20 clean as	11/03/08
	June 19, 2008 and "Monitor weights x 4 reduction diet." The quarterly MDS 10 and September 9 resident in Section I change program." A face-to-face interconducted on September 2 resident in Section I change program."	August 14, 2008, directing, 4 weeks; resident is on weight assessments completed June 9, 2008 failed to code the K as "On a planned weight view with Employee #3 was ember 19, 2008 at 10:30 AM. led that the MDS assessments		Monitor condition of lights and corrective action as needed. Report monitoring results and actions to the QI committee quarter.	corrective	,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	٠	095034	B. WING _	·	09/1	9/2008
	ROVIDER OR SUPPLIER	& REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 278 F 279 SS=D	September 19, 200 483.20(d), 483.20(d) PLANS A facility must use develop, review and comprehensive pla The facility must deplan for each reside objectives and time medical, nursing, a needs that are identical assessment. The care plan must be furnished to attath highest practicable psychosocial well-band any services that under §483.25 but resident's exercise including the right to §483.10(b)(4). This REQUIREMENT Based on record refacility staff failed to appropriate goals a residents for potentiuse of nine (9) or medical to the service of the service	the results of the assessment to drevise the resident's nof care. Evelop a comprehensive care ent that includes measurable tables to meet a resident's not mental and psychosocial tified in the comprehensive I describe the services that are to in or maintain the resident's physical, mental, and reing as required under §483.25; at would otherwise be required are not provided due to the of rights under §483.10, or refuse treatment under NT is not met as evidenced by: View and staff interview for two residents, it was determined that or develop care plans with and approaches for two (2) ial adverse interaction for the more medications and one (1) is. Residents # 1 and 15	F 278	483.20(g) - (j) RESIDENT ASS 1. Resident # 4 was reviewed	by the floor with MDS led on the inge arts that ined hen make ction K ance and in K utrition er will y and review in MDS ger will ind corrective	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUP COMPLET	
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	OVIDER OR SUPPLIER	REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 279	1. Facility staff failed potential adverse into or more medications. A review of the clinic revealed physician's August 5, 2008 that medications: Clopidd Potassium Chloride Zolpiderm Tatrate (ATylox, Albuterol, Adv. Carbonate/Vitamin ECD) and Docusate State A review of the medications of the medicassessment on June was allergic to PCN and physical indicate PCN. A review of care plan devand approaches for interactions involving medications or allerged A face-to-face interv. Employee #5 at approaches for interactions involving medications are medications are The record was reviewed.	I to develop a care plan for the eraction for the use of nine (9) and allergies for Resident #1. cal record for Resident #1 orders dated and signed include the following ogrel Bisulfate (Plavix), (K-Dur), Sertraline HCL (Zoloft), ambein), Olanzapine (Zyprexa), vair Diskus, Calcium O3, Diltiazem HCL (Cardizem Godium (Colace). cal record revealed that allergy to Penicillin (PCN) on eart. The facility admission e 21, 2008 indicated the resident and ASA (Aspirin). The history ed the resident was allergic to the resident was allergic to the slast updated on August 21, nere was no problem identified veloped with appropriate goals potential adverse drug the use of nine (9) or more gies. few was conducted with roximately 4:00 PM on He/she acknowledged that re plans for the potential tion for the use of nine (9) or	F 279	1.) 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PL 1. Resident #1Careplan was uper reflect 9 or more meds and alle 2. All residents with 9 or more mallergies will be care planned. 3. Staff will be educated on the individual of care planning 9 or more meds allergies. 4. Care plan audits will be done the Nurse Manager or designee submitted to Director of Nursing presented at quarterly QI meeting. 2.) 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PL 1. Resident # 15 Careplan was uperflect 9 or more meds usage. 2. All residents with 9 or more meds usage. 3. Staff will be educated on the individual of care planning 9 or medication 4. Care plan audits will be done Nurse Manager or designee and to Director of Nursing to be president in the president of t	dated to rgies. neds and mportance and monthly by and to be ng	9/18/08 11/3/08 11/3/08 10/9/08 09/18/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	·	095034	B. WIN	G		09/1	9/2008	
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE	
F 279	the potential advers nine (9) or more me A review of the clinic physician's order da and renewed withou 2008 that included the Amlodipine Besylate Vitamins), KCL (Pot Vitamin E, MPAP (A Aminophenol/Tylend Xalatan Eye Drops. A review of the care July 1, 2008 revealed identified and no call appropriate goals are adverse drug interaction of the care (9) or more medication. A face-to-face interved Employee #3 at app September 18, 2008 the record lacked as a september 2008 the record	e drug interactions for the use of dications for Resident #15. cal record for +5 revealed a ted and signed June 19, 2008 at any changes on August 7, he following medications: e, Furosemide, MVI (Multiple assium Chloride), Seroquel, acetyl-Parabl), Cosopt Eye Drops and plan that was last updated on d that there was no problem the plan developed with and approaches for potential citions involving the use of nine tons. iew was conducted with roximately 9:30 PM on the Ishe acknowledged that care plan for use of nine (9) or The record was reviewed on	F:	279				
F 280 SS=D	CARE PLANS The resident has the	e right, unless adjudged rwise found to be incapacitated	F2	280				
	under the laws of the planning care and treatment. A comprehensive ca within 7 days after the comprehensive assets.	e State, to participate in eatment or changes in care and are plan must be developed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	DING	(X3) DATE SUI COMPLET	
	095034	B. WING	3	09/1	9/2008
NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING &	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETION DATE
the resident, and oth disciplines as detern and, to the extent provided the resident, the resident revised by a team of assessment. This REQUIREMEN Based on observation review for five (5) of determined that faciliplans for: one (1) resident for rone (1) resident for and falls; one (1) resident for and falls; one (1) residents #1, 2, 8, 1 The findings include: 1. Facility staff failed plan for Resident #1 approaches to protect facility with unauthor A review of the clinical for Elopement" care 2008. The goal states: "Re	ed nurse with responsibility for the appropriate staff in appropriate staff in hined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed and qualified persons after each. This not met as evidenced by: In, staff interview and record and applied records, it was ity staff failed to update care sident to include visitor activity; multiple falls and code status; a skin breakdown, fluid intake ident for integration of Hospice president for elopement risk. The staff interview and record and the staff failed to update care sident to include yield intake ident for integration of Hospice president for elopement risk. The staff interview and record as the staff failed to update care to include yield interview. The staff interview and record as the staff failed to update care to include goals and the staff failed to update the elopement care to include goals and the resident from leaving the ized visitors. The staff interview and record and interview and record include goals and the staff failed to update the elopement care to include goals and the resident from leaving the ized visitors. The staff interview and record and record include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update the elopement care to include goals and the staff failed to update care st	F 2	1.) 483.20(d)(3), 483.10(k) COMPREHENSIVE CA 1. Elopement care plan ha to include directions from a party regarding LOA instructions will be care pla 3. Staff will be inserviced of special LOA instructions. 4. Care plan audits will be Nurse Manager or designed to Director of Nursing to be quarterly QI meeting	RÉ PLANS us been revised responsible actions for al LOA anned. on residents with done monthly by ee and submitted	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE (ASHINGTON, DC 20017		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 280	shift and P.R.N (2) Picture at front of (3) Sign out for Leap protocol. (4) Resident/staff exprotocol. Evaluation document "LOA [Leave of absorder obtained from A face-to-face interved Employee #10 on Set He/she stated that the had concerns about #1 taking the resident of having him/her waccount using an AT The resident's response hew/niece who listated, "I spoke with Monday (August 11, concerns with [him/hme that it was okay for [Visitor #1]. However want [Visitor #1] to tafacility." The Leave of Abserindicated that the resident on the following of August 14, 2008 from August 14, 2008 from August 15, 2008 from August 18, 20	is wearing "Watchmate" every lesk. ve of absence (LOA) per ducation on leaving and leted: ence] with responsible party Primary MD [Medical Doctor]" liew was conducted with eptember 19, 2008 at 11:00 AM. he Interdisciplinary Team (IDT) Visitor ht off premise and the possibility lithdraw funds from a bank IM (Automatic Teller Machine). Insible party was his/her ves out of state. Employee #10 the responsible party on 2008) and shared our (IDT) ler]. The responsible party told for [Resident #1] to visit with er, [responsible party] did not lake [Resident #1] out of the lice form for Resident #1 sident was signed out by Visitor	F	280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/1	9/2008
	NOVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017	•	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 280	August 22, 2008 fro August 23, 2008 fro August 25, 2008 fro September 10, 2008 There was no evide updated to reflect th nor was a physician Additionally, all staff who the resident co record was reviewed 2. Facility staff failed Resident #2 for falls A. Facility staff failed on the Floor" care p tool/Fall risk action papproaches for Reswithout injury. A review of the IDT following: June 22, 2008 at 19 slipping to the floor June 24, 2008 at 07 bathroom on the flood discomfort." July 23, 2008 at 193 resident slid to floor injuries" August 6, 2008 at 11 120 that the reside injury noted"	m 12:45 PM - 2:15 PM m 2:15 PM - 3:30 PM m 1:40 PM - 2:30 PM B from 1:35 PM - 2:50 PM nce that the care plan was be responsible party's directions is order obtained. If were not knowledgeable about and leave the facility with. The d September 17, 2008.	F.	280	2A.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PI 1. Resident # 2 care plan was uperflect new intervention. 2. All Resident's Fall Risk Indica Fall Risk Action Plan will be revisupdated to reflect changes in the interventions if necessary. 3. Staff will be in serviced regard updating Fall Risk Indicator Tool Action Plan after each fall to reflegoals for prevention of further of 4. Monthly fall audits will be done and submitted to Director of Nurreporting to quarterly QI meeting	tor Tool/ ewed and c current ding // Fall Risk ect current ccurrences e by QI sing for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) M A. BUII		i c	(X3) DATE SURVEY COMPLETED	
•		095034	B. WIN			00/10	9/2008
NAME OF PROVIDER OR SUPPLIE CARROLL MANOR NURS				7	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		5/2006
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHOU TAG REFERENCED TO THE APPROPRIAT			(X5) COMPLETION DATE
s/p [status posupdated with mark pall May 28 the current plate s/p fall June 24 new action/apps/p fall July 23 new action/apps/p fall August to the current part pall August to the current part pall Additionally, the action plan" when Resident A face-to-face September 16, Employee #4. of care for Resupdated each precord was reversely a face plan for Resupdated pall part pall part pall part pall pall pall pall pall pall pall pal	t] fall ewad, 2000 road oroad of 2000 for 2000 f	May 24, 2008 - plan of care ctions/approaches 8- no new actions/approaches to are documented 98- plan of care updated with hes documented 8 plan of care updated with hes documented 08- no new actions/approaches f care documented 08- no new actions/approaches f care documented vidence that a "Fall risk action plan" was completed ad a fall on June 22, 2008. Il risk indicator tool/Fall risk at consistently updated/amended was identified as having a fall. The acknowledged that the plan #2 was not consistently he resident had a fall. The dign september 16, 2008.	F	280	2B.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 1. Care plan was updated to reflect curr Code status. 2. All residents records will be review. To ensure the code status is updated Care planned. 3. Staff will be inserviced on updating Care planning of code status. 4. Monthly audits will be done by Nurs Manager or designee and submitted t DON for reporting quarterly QI meeting	rent yed d and g and rse to	9/16/08 11/3/08 11/3/08 10/9/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL			(X3) DATE SURVEY COMPLETED		
٠		095034	B. WIN	G		09/19	9/2008	
	OVIDER OR SUPPLIER	REHAB		7	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE NASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIATE DEFICIE		(X5) COMPLETION DATE	
F 280	by the physician onAdvanced Directive A review of the Adm Exam form complete Advance Directives: A review of the care plan and a full code 5, 2008. The record lacked e Directive care plans approaches to addressatus. A face-to-face interv September 16, 2008 Employee #4. He/sh aforementioned care the current code stativas reviewed on Se 3. Facility staff failed Alteration in Skin Integrity care plansinght toe for Resident A review of the care Integrity" last update "sacral, right ankle, a A dressing change of	August 12, 2008 directed, " res: Full Code" iission and Annual Physical ed May 5, 2008 revealed, " DNR [do not resuscitate]" plans revealed a DNR care care plan last updated August vidence that the Advance were updated with goals and ess Resident #2's current code iew was conducted on at approximately 2:40 PM with he acknowledged that the e plan(s) were updated to reflect tus for Resident #2. The record ptember 16, 2008. d to update the care plans for egrity, Hx (history) of UTI, and falls for Resident #8. d to revise the "Alteration in Skin to include the open area to the		280	3A.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLAN 1. Care plan was updated to reflect skin integrity on right toe for Resider 2. All residents with altered skin inte will be reviewed and updated. 3. Staff will be in serviced on the importance of updating care plans for alterations in skin integrity. 4. Monthly audits will be conducted I Nurse Manager or designee and subto Director of Nursing for reporting to quarterly QI meeting.	altered nt # 8 egrity or skin by bmitted	9/16/08 11/3/08 11/3/08 10/9/08	
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		` ´cc	(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENC		(X5) COMPLETION DATE
F 280	#15. An open area observed. A face-to-face interv September 16, 2008 He/she "The sacral a healed. The right ar current open areas" The record lacked et Skin Integrity" care papproaches to address to address to address to accord was reviewed. A face-to-face interv September 16, 2008 He/she acknowledge plan was not update record was reviewed. B. Facility staff failed [urinary tract infection current fluid intake for A review of the care July 31, 2008 reveal Encourage and more day" The physician's order directed, "Encourage 2500 ml/day" The record lacked explan was updated with address the current for several contractions.	view was conducted on 3 at 3:55 PM with Employee #5. and the left leg ulcers are nkle and the right 5th toe are the evidence that the "Alteration in plan was updated with goals and less the open area to the right view was conducted on 3 at 3:55 PM with Employee #5. ed that aforementioned care ed to include the right toe. The don September 16, 2008.	F2	280	3B.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 1. Care plan was updated to reflect cufluid intake for Resident # 8 2. All residents with specific fluid intake orders will be reviewed to ensure the orders are followed. 3. Staff will be in serviced on the importance of care planning specific fluintake for each resident. 4. Monthly audits will be conducted by Nurse Manager or designee and submitted to Director of Nursing for reporting to quarterly QI meeting	e uid	9/16/08 11/3/08 11/3/08 10/9/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) . COMPLETION DATE
F 280	September 16, 2008 He/she acknowledg plan was not update for fluid intake. The September 16, 2008 C. Facility staff failed for Falls" care plan without injury. The nursing notes of [7:30 PM] revealed, room right side of [h kneeling position" The record lacked e Risk for Falls" care and the "Falls Risk I with goals and approx fall. A face-to-face interv September 16, 2008 He/she acknowledge plan was not update was reviewed on Set 1. Facility staff failed plan for Resident #1 A review of Resident physician's order date.	at 3:55 PM with Employee #5. ed that aforementioned care ed to include the current order record was reviewed on 3. d to revise the "Resident at Risk after Resident #8 had a fall ated June 30, 2008 at 1930 "Resident was found in [his/her] is/her] bed holding onto bed in vidence that the "Resident at plan last reviewed July 31, 2008 ndicator Tool" was updated baches to address the resident' riew was conducted on 3 at 3:55 PM with Employee #5. ed that aforementioned care and to include the fall. The record eptember 16, 2008. It to integrate the hospice care 3. t #13's record revealed a ted May 1, 2008 directing,	F 2		3C.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PL 1. Resident # 8 care plan and Fa Indicator Tool was updated with approaches to address her fall. 2. For all falls, the Fall Risk Indic Tool/Fall Risk Action Plan will be completed and updated with go approaches to address fall. 3. Staff will be in serviced on impupdating Fall Risk Indicator Tool Action Plan after each fall with go approaches to address fall. 4. Monthly fall audits will be done Nurse and submitted to Director for reporting to quarterly QI meet 4. 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PL 1. Hospice care plan was integra current care plan for resident # 1 2. There are three additional hos residents. Their plans of care we reviewed and integrated into the Hospice plan of care. 2. Staff will be in sequenced on inter-	all Risk goals and ator e als and cortance of /Fall Risk coals and e by QI of Nursing ting. ANS ated with 3 apice care are	9/16/08 11/03/08 11/3/08 10/9/08
	Disease." A care p initiated the same da A physician's order o "Refer to [Hospice Control or the control of the	dated August 18, 2008 directed,			 Staff will be in serviced on interesting hospice plan of care with resident plan of care. Monthly care plan audits will be conducted by Nurse Manager or and submitted to Director of Nurse presentation to quarterly QI meets. 	e designee sing for	

NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB SUMMARY STATEMENT OF DEPICIENCIES PROPERLY TAG SUMMARY STATEMENT OF DEPICIENCIES PROPERLY TAG CONTINUED FOR PROVIDER OR SUPPLIA REGULATORY OR LSC INSTRUMENT OF DEPICIENCIES PROVIDERS PLACED TO THE APPROPRIATE DEPICIENCY TAG F 280 Continued from page 2 decident investigation of the resident or separate from the resident's chart. A face-to-face interview was conducted on September 17, 2008 at 8:15 AM with Employee #5. He/shie stated, 11 is the responsibility of the nurse caring for the resident to read what's in the hospice binder. We don't record or write down that we read the hospice binder. We don't record or write down that we read the hospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder. We don't record or write down that we read the nospice binder when the resident were revealed documentation of three (3) elopement episodes. A review of the clinical record for the resident revealed documentation of three (3) elopement episodes. First episode occurred on May 20, 2008. According to a nurse' s note dated May 22, 2008. Tesident to a nurse' s note dated May 22, 2008 a nurse documentad, "Resident is very confused out of bed and dressed. Tried to go down stairs, said 'I am going home. I need to get to my home.' Continues to wander along the hallway, said 'I need a cab to get out of here: At 2.115 PM on June 2, 2008 a second episode was documented in a nurse' s note, "Resident wandered to 1st floor and sat in lobby."		OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS CITY, STATE ZIP CODE T25 BUCHANAN ST., NE WASHINGTON, DC 20017 PROPER TAG F 280 Continued From page 24 conducted on August 25, 2008 at 3:00 PM. A care plan was developed by the hospice company and was maintained in a binder separate from the resident's chart. A face-to-face interview was conducted on September 17, 2008 at 8:15 AM with Employee #5. Helshe stated, "Its the responsibility of the nurse caring for the resident to read what's in the hospice binder." We don't record or write down that we read the hospice binder." Employee #5 acknowledged that the two (2) care plans were not integrated. The record was reviewed September 17, 2008. 5. Facility staff failed to update the elopement episodes. A review of the clinical record for the resident revealed documentation of three (3) elopement episodes. First episode occurred on May 20, 2008. According to a nurse's note dated May 22, 2008. "Resident was reported found on [name of transportation company] after wandering off unit." At 2310 [11:10 PM] on May 22, 2008 a nurse documented, "Resident is very confused out of bed and dressed. Tried to go down stairs, said "I am going home. I need to get to my home." Continues to wander along the hallway, said 'I need a cab to get out of here." At 12:15 PM on June 2, 2008 a second episode was documented in a nurse's sole; "Resident wandered	l		095034	B. WING	G		09/1	9/2008	
F 280 Continued From page 24 conducted on August 25, 2008 at 3:00 PM. A care plan was developed by the hospice company and was maintained in a binder separate from the resident schart. A face-to-face interview was conducted on September 17, 2008 at 8:15 AM with Employee #5. He/she stated, "It is the responsibility of the nurse caring for the resident to read what's in the hospice binder." Employee #5 acknowledged that the two (2) care plan were not integrated. The record was reviewed September 17, 2008. 5. Facility staff failed to update the elopement care plan for Resident #27 with three (3) elopement episodes. A review of the clinical record for the resident revealed documentation of three (3) elopement episodes. First episode occurred on May 20, 2008. According to a nurse' s note dated May 22, 2008. "Resident was reported found on Iname of transportation company) after wandering off unit." At 2310 [11:10 PM] on May 22, 2008 a nurse documented, "Resident is very confused out of bed and dressed. Tried to go down stairs, said 'I am going home. I need to get to my home.' Continues to wander along the hallway, said 'I need a cab to get out of here." At 12:15 PM on June 2, 2008 a second episode was documented in a nurse' s note, "Resident wandered of the processing of the processing of the nurse' snote, "Resident wandered of the processing of the nurse' snote, "Resident wandered of the processing of the nurse' snote of the processing of the nurse of the nurs			REHAB		72	25 BUCHANAN ST., NE	,		
conducted on August 25, 2008 at 3:00 PM. A care plan was developed by the hospice company and was maintained in a binder separate from the resident's chart. A face-to-face interview was conducted on September 17, 2008 at 8:15 AM with Employee #5. He/she stated, "It is the responsibility of the nurse caring for the resident to read what's in the hospice binder." Employee #5 acknowledged that the two (2) care plans were not integrated. The record was reviewed September 17, 2008. 5. Facility staff failed to update the elopement care plan for Resident #27 with three (3) elopement episodes. A review of the clinical record for the resident revealed documentation of three (3) elopement episodes. First episode occurred on May 20, 2008. "Resident was reported found on [name of transportation company] after wandering off unit." At 2310 [11:10 PM] on May 22, 2008 a nurse documented, "Resident is very confused out of bed and dressed. Tried to go down stairs, said 'I am going home. I need to get to my home.' Continues to wander along the hallway, said 'I need a cab to get out of here." At 12:15 PM on June 2, 2008 a second episode was documented in a nurse' s note, "Resident wandered"	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX		(EACH CORRECTIVE ACTION SHOULD B	E CROSS-		
	F 280	conducted on Augus plan was developed was maintained in a resident's chart. A face-to-face interv September 17, 2008 He/she stated, "It is caring for the reside binder. We don't red the hospice binder." Employee #5 acknow plans were not integ reviewed September 5. Facility staff failed plan for Resident #2 episodes. A review of the clinic revealed documental episodes. First episode occurre to a nurse's note da was reported found ocompany] after wand documented, "Residand dressed. Tried a going home. I need to wander along the get out of here." At 12:15 PM on June documented in a nur	st 25, 2008 at 3:00 PM. A care by the hospice company and binder separate from the siew was conducted on at 8:15 AM with Employee #5. The responsibility of the nurse nt to read what's in the hospice cord or write down that we read wledged that the two (2) care trated. The record was r 17, 2008. It to update the elopement care 7 with three (3) elopement cal record for the resident ation of three (3) elopement ed on May 20, 2008. According the don May 20, 2008. Resident on [name of transportation dering off unit." On May 22, 2008 a nurse ent is very confused out of bed to go down stairs, said 'I am to get to my home.' Continues hallway, said 'I need a cab to e 2, 2008 a second episode was ree' s note, "Resident wandered"	F 2		COMPREHENSIVE CARE PL 1. Resident # 27 Care Plan was and updated to ensure that resid not leave facility unaccompanied 2. The care plan of all residents a elopement, will be reviewed and 3. Staff will be inserviced on Res Elopement Prevention Policy 4. Monthly audits will be conduct Nurse Manager or designee and to Director of Nursing for reportir	revised lent will not l. at risk for updated. sident ted by submitted	11/3/08 11/03/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G	·	09/1	9/2008
	OVIDER OR SUPPLIER	REHAB	•	725	ET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017		
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F 280	Continued From pag	ge 25	F	280			
	notes on July 12, 20	documented in the nurse's 08. At 1320 [1:20 PM] a nurse lent found on 4th floor in room					
	, , , , , , , , , , , , , , , , , , , ,	ch Mate Care Plan revealed esident will not wander and be ed."					
	the plan was initiate was, "Resident will next 90 days." The first goal date w	d a start date to indicate when d. The goal for the problem have no further wandering over as June 19, 2008 and the as September 18, 2008.					
	" Obtain a watch manumber. Apply bracelet to resessort resident to are The above listed gooundated care plan. Further review of the	nd from unit activities. als were all a part of the initial e care plan failed to reveal any inches to prevent additional			·		
	Employee #7 at app September 19, 2008 the care plan lacked approaches to preve elopement after the	iew was conducted with roximately 9:30 AM on the land that appropriate goals and ent further episodes of above cited episodes. The digital on September 19, 2008.					
F 282 SS=D		IPREHENSIVE CARE PLANS ed or arranged by the facility	F	282			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING	÷		09/1	9/2008	
	OVIDER OR SUPPLIER	REHAB		725	ET ADDRESS, CITY, STATE, ZIP CODE IS BUCHANAN ST., NE ASHINGTON, DC 20017			
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F 282	accordance with each care. This REQUIREMEN Based on record rev (1) of 30 sampled refacility staff failed to "Pain Management" The findings include A review of the "Pain updated July 15, 200 document for pain Coneeded] utilizing pain	r qualified persons in ch resident's written plan of a resident's written plan of a resident's written plan of a revealed, "1. Assess and the resident plan property is revealed," 1. Assess and the resident plan property is revealed, "1. Assess and the reverse plan plan property is revealed," 1. Assess and the reverse plan property is revealed, "1. Assess and the reverse plan property is revealed," 1. Assess and the reverse plan property plan property plan property plan property plan property plan property plan plan property plan plan property plan plan property plan plan plan plan plan plan plan plan	F 2	F F F F F F F F F F F F F F F F F F F	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 1. Care plan for pain assessmen Resident # 11 was updated to re facility policy for monitoring chroic 2. All residents with chronic pain Reviewed to ensure the facility p Protocol to assess every eight he Adhered to. 3. Staff will be inserviced on the pain protocol of assessing reside every eight hours. 4. Monthly pain audit will be done Manager or designee and submi Director of Nursing to present in QI meeting.	ot for iflect inic pain will be ain ours was chronic ents e by Nurse tted to	9/19/08 11/3/08 11/3/08 10/9/08	
F 286 SS=D	revealed that pain as every shift. A face-to-face interv September 19, 2008 He/she acknowledge were not conducted reviewed on Septem 483.20(d) RESIDEN A facility must maint	iew was conducted on at at 9:50 AM with Employee #5. ed that the pain assessments every shift. The record was aber 18, 2008. T ASSESSMENT - USE	F 28	1	183.20(d) RESIDENT ASSESSME	revious	11/3/08	
·	resident's active rec	previous 15 months in the ord. T is not met as evidenced by:			closed record of March 31 was place current record.	ea in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING _	· —	09/1	9/2008
CARROL	L MANOR NURSING	& REHAB TATEMENT OF DEFICIENCIES		REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRI		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATION	LD BE CROSS-	COMPLETION DATE
F 286	Based on record re (1) of 30 sampled re facility staff failed to Minimum Data Set resident's active red. The findings included a review of Resider revealed the follow MDS Assessment resection AA 8a was the above] and Section AA 8a was the above] and Section AA 8b was assessment]. A review of Resider was coded as 00 [in Section AA. 8b was assessment]. A review of Resider that he/she was dis March 31, 2008 and discharge summary. Upon review of Resident as a part of the property of the section of	eview and staff interview for one esidents, it was determined that or maintain 15 months of (MDS) assessments on the cord. Resident #5. e: Int #5's current clinical record ing: reference date April 12, 2008, coded as 00 [indicating none of ction AA. 8b was coded as 5 sion/return assessment]. Ind April 21, 2008, Section AA 8a andicating none of the above] and is coded as 7 [Medicare 14 day and it #5's closed record revealed in the physician completed a completed March 25, 2008 was art of the closed record. In the closed record in the facility on the closed record. In the closed record in the facility on the closed record. In the closed record in the facility on March in anticipated. Resident #5 was accility on April 8, 2008 and a full red cledged that the admission MDS	F 286	483.20(d) RESIDENT ASSESS 2. Review all records of reside Currently receiving Medicare Benefits and of other current who have received Medicare within the last 15 months to in 15 months of MDS Assessment open record. 3. Facility policy has been rereflect consistent maintenanch hospitalized resident's medical All records will be considered period of 30 days following a The hospital. Any resident where exceeds 30 days will require upon the resident return to the 4. Will monitor on a monthly report to QI Committee 5. Completion date.	dents Part A residents A benefits asure that ents are in the vised to e of al records. open for a transfer to nose stays a new chart e facility.	11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095034	B. WIN	ıG	<u> </u>	09/1	9/2008
	ROVIDER OR SUPPLIER	& REHAB		72	ET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
F 286 F 309 SS=E	have been on the oreviewed on Septen 483.25 QUALITY Comprehensive assignments of the provide the necess maintain the highest and psychosocial work comprehensive assignments of the provide the necess maintain the highest and psychosocial work comprehensive assignments of the provide the provided in the	urrent record. The record was mber 18, 2008. F CARE receive and the facility must ary care and services to attain or at practicable physical, mental, well-being, in accordance with the ressment and plan of care. NT is not met as evidenced by: on, staff interview and record of 30 sampled residents and six sidents, it was determined that or follow up on psychiatric and weight loss and clarify a tes Mellitus for one (1) resident; dent received 2 liters of water swallowing guideline for one (1) pain during a dressing change is; ensure two (2) residents on; follow up on a psychiatric and for weight loss for one (1) ers for daily catheterization for liminister a nutritional supplement orders for five (5) residents, ons as per physician's orders for and administer medications per diffications for one (1) resident. 7, 8,13, 16, 28, JH1, JH2, JH3,		286			
	The findings include	3 :					·

NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB TOWN 10 PREFIX TAGS GEACH DEPOCING WINDS THE PRECEDOR OF THE REGULATORY TAG CACH DEPOCING WINDS THE PRECEDOR OF THE REGULATORY TAG COntinued From page 29 1. Facility staff failed to follow a physician's order for a Psychiatric Consult and a Speech Consult for Resident #3 after hershe suffered a significant weight loss and ansure that the resident received medications ordered by the physician. A. Review of the clinical record revealed a Physician's order for a Psychiatric Consult are consult weight loss and susure that the resident received medications ordered by the physician. A. Review of the clinical record revealed a Physician's order for a Psychiatric and Speech Consult for Resident #3. Further review of the clinical record revealed a Physician so reversible to the clinical record revealed that the Dietary consult was completed on July 25, 2008 but the Psychiatric and Speech consults were not be clinical record revealed that the Psychiatric and Speech consults were not done. He/she added "I am very sorry." I will do them immediately." The record was reviewed on September 15, 2008. B. The facility staff failed to ensure that Resident #3 revealed a Consultant Pharmacists Communication Report dated August 5, 2008 which stated "Low Calcium level recorded on 71/4/08. Please consider adding Calcium 500 mg with Vitamin D PO [by mouth) Bid [twice daily] routinely to this resident's medication regimen. A review of the Response section of the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
PREFIX TAG CAGNIDE CAGNIDER CAGNIDER			095034	B. WING	<u> </u>		09/1	9/2008
F 309 Continued From page 29 1. Facility staff failed to follow a physician's order for a Psychiatric Consult and a Speech Consult for Resident #3 after he/she suffered a significant weight loss and ensure that the resident received medications ordered by the physician. A Review of the clinical record revealed a Physician's fore dated July 24, 2008, "Dietary Consult, Psych [Psychiatric] Consult and Speech Consult for weight loss." Further review of the clinical record revealed that the Dietary consult was completed on July 25, 2008 but the Psychiatric and Speech Consults were never done. A face-to-face interview was conducted with Employee #5 at approximately 9:35 AM on September 16, 2008. He/she acknowledged that the Psychiatric and Speech consults were not done. He/she added "I am very sorry. I will do them immediately." The record was reviewed on September 15, 2008. B. The facility staff failed to ensure that Resident #3 revealed a Consultant Pharmacist and ordered by the physician. A review of the clinical record for Resident #3 revealed a Consultant Pharmacists Communication Report dated August 5, 2008 which stated "Low Calcium level recorded on 71/408. Please consider adding Calcium Four Percorded on 97/4108. Please consider adding Calcium Four Percorded on 97/4108. Please consider adding Calcium Four Percorded on 71/4108. Please consider adding Calcium Four Percorded on 7			REHAB		72	25 BUCHANAN ST., NE		
1. Facility staff failed to follow a physician's order for a Psychiatric Consult and a Speech Consult for Resident #3 after he/she suffered a significant weight loss and ensure that the resident received medications ordered by the physician. A. Review of the clinical record revealed a Physician's order dated July 24, 2008, "Dietary Consult, Psych [Psychiatric] Consult and Speech Consult for weight loss." Further review of the clinical record revealed that the Dietary consult was completed on July 25, 2008 but the Psychiatric and Speech Consults were never done. A face-to-face interview was conducted with Employee #5 at approximately 9:35 AM on September 16, 2008. He/she acknowledged that the Psychiatric and Speech consults were not done. He/she added "I am very sorry. I will do them immediately." The record was reviewed on September 15, 2008. B. The facility staff failed to ensure that Resident #3 reveiled a Consultant Pharmacist and ordered by the physician. A review of the clinical record for Resident #3 revealed a Consultant Pharmacist's Communication Report dated August 5, 2008 which stated "Low Calcium level recorded on 71/4/08. Please consider adding Calcium 500 mg with Vitamin D PO (by mouth) Bid (twice daily) routinely to this resident's medication regimen." A review of the Response section of the	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	
	F 309	1. Facility staff failed a Psychiatric Consu Resident #3 after he weight loss and ensimedications ordered A. Review of the clin Physician's order da "Dietary Consult, Ps Speech Consult for the Dietary consult when but the Psychiatric and the Psyc	It to follow a physician's order for It and a Speech Consult and It by the physician. Inical record revealed a ted July 24, 2008, ych [Psychiatric] Consult and weight loss." It clinical record revealed that was completed on July 25, 2008 and Speech Consults were It is was conducted with roximately 9:35 AM on It. He/she acknowledged that Speech consults were not done. It is were not done. It is were not done. It is were that the speech consults were not done. It is well allowed on September 15, 2008. It is alled to ensure that Resident allowing and Vit. [Vitamin] D "It is pharmacist and ordered by the speech considering with Vitamin D PO [by it] it is resident's "	F 3	009	1. Psych consult and speech corcompleted for Resident # 3. 2. All residents identified with sig weight loss will be placed on the loss protocol which consist of coby dietary, pharmacy and speech weights are done weekly. 3. Staff will be reinserviced on the importance of following the weigh protocol and to ensure the Speech Pharmacy and Dietary consults at the Monthly weight loss audits will by Nurse Manager or designee as submitted to Director of Nursing present in quarterly QI meeting. 1B.) 483.25 QUALITY OF CARE 1. Order written for Calcium and for Resident # 3. 2. All residents with pharmacy recommendations agreed by phy will be reviewed and carried out. 3. Staff will be in serviced on proreviewing pharmacy recommend 4. Monthly consult audits will be Nurse Manager or designee and submitted to Director of Nursing and submitted to Director of Nursing and submitted in the place of the pla	unificant weight nsults n their e ht loss ch, are done. I be done and to Vitamin D vsician tocol for lations. done by	9/18/08 11/3/08 11/3/08 11/3/08

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X2) MULTIPLE CONSTRUCTION (X3) DAT CON	
095034 B. WING		09/19/2008
CARROLL MANOR NURSING & REHAR	ADDRESS, CITY, STATE, ZIP CODE UCHANAN ST., NE HINGTON, DC 20017	33.13.233
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS- COMPLETION
2. Facility staff failed to follow physician's orders and ensure that Resident #4 received two (2) liters (L) of fluid daily. A review of Resident #4 record revealed a physician's order dated August 14, 2008 directing, "Increase PO (oral) fluids 2 L/day. D =1000 ml, E=800 ml, N=200 ml." According to the "Resident I/O (intake/output)" and and according to the resident consumed the following amount of fluids:	483.25 QUALITY OF CARE Order was reviewed by physici stermined 1500 mL/ day fluid is resident # 4. All residents with specific fluid ders will be reviewed and adhe Staff will be in serviced on the portance of documenting PO fluid d what constitutes PO fluids. Monthly intake and output audi ne by Nurse Manager or design bmitted to Director of Nursing to quarterly QI meeting.	intake 11/3/08 red to 11/3/08 uid intake its will be nee and

A. BUILDING		COMPLETED
	G	
095034 B. WING		09/19/2008
CARROLL MANOR NURSING & REHAB	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE NASHINGTON, DC 20017	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS- COMPLETION
F 309 Continued From page 31 September 11, 2008 - 1380 September 14, 2008 - 1320 September 15, 2008 - 1360 A face-to-face interview with Employee #3 was conducted on September 17, 2008 at 8:15 AM. He/she acknowledged that Resident #4 had not received two (2) liters of water daily as per physician's orders. The record was reviewed September 17, 2008. 3. Facility staff failed to follow the "Safe Swallow Guide" for Resident #7. A review of Resident #7's record revealed, "Safe Swallow Guide" dated July 21, 2008. The guide included the following: "Regular plate with plate guard; assist resident with cutting food into small manageable pieces; resident should swallow and clear mouth prior to next bite; alternate solids and liquids." The resident was observed at the lunch meal on September 16, 2008 from 12:20 PM through 12:35 PM. The menu consisted of meatballs, spaghetti, asparagus, fruit cocktail and milk. Water was also provided. There was no plate guard. Resident #7 received no assistance with cutting up the meatballs and spaghetti. The resident consumed all of the solid foods first then drank the milk and water. According to the resident's record, weights were recorded as follows for 2008: January 124.8 pounds February 122.7 March 108.4	3.) 483.25 QUALITY OF CARE 1. Resident # 7 was assessed by Therapist and was determined the Swallow Guide and plate guard volonger needed. 2. All residents identified on a sare Guide will be reviewed to ensure guides are adhered to. 3. Staff will be in serviced on the importance of adhering to Safe Sudide instructions. 4. Monthly Safe Swallow Guide and submitted to Director of Nurspresent to quarterly QI meeting.	nat Safe was no Ife Swallow the 11/03/08 Swallow audit will esignee

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		,	(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/19	9/2008
	OVIDER OR SUPPLIER	REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFI	CROSS-	(X5) COMPLETION DATE
F 309	Employee #4 on Sep He/she stated, "(Re assistance or a plate discontinued this ord reviewed on Septem 4. Facility staff failed pain during the dress. A wound treatment of September 16, 2008. During the dressing ankle and right toe, I leg of the resident redressing. At this time employee continued the dressing was rer the right leg again to resident moaned and cleansing process. Vight leg to apply klin moaned and yelled. room during the dress resident, "It's almost continued to apply tarting the dressing the	iew was conducted with otember 16, 2008 at 1:00 PM. sident #7) no longer requires guard. I should have der long ago." The record was ober 16, 2008. It to reassess Resident #8 for sing change. Observation was conducted on at 11:32 AM for Resident #8. Change to Resident #8's right employee #15 raised the right emove the old visibly soiled be Resident #8 moaned and the to remove the dressing. After moved, Employee #15 raised clean the right ankle, the discontinued to moan during the When Employee #15 raised the git to the right ankle the resident Employee #5 [who entered the sing change] stated to the done." Employee #15 raised to the done." Employee #15 raised to the tothe dressing.	F;	309	4.) 483.25 QUALITY OF CARE 1. Resident # 8 was medicated for prior to dressing change, reassess pain during dressing change and medicated as needed. 2. Resident with dressing changes assessed for pain prior to and reasthroughout the dressing change. 3. Staff will be inserviced on pain for dressing changes. 4. Monthly treatment competencied done by the Wound Nurse and sul Director of Nursing for presenting Committee meeting for review	sed for s will be assessed protocol es will be abmitted to	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/19	9/2008	
	ROVIDER OR SUPPLIER	REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE	
F 309	Continued From pag	ge 33	FS	309				
	received the Os-cal	I to ensure that Resident #13 D as ordered by the physician.			5.) 483.25 QUALITY OF CARE 1. Order for OS-Cal D was clarif administered per physicians ord Resident # 13.		9/17/08	
	"Consultant Pharma August 5, 2008. The patient is taking Cale	t #13's record revealed a cist Communication" form dated e recommendation was , "This cium Carbonate 600 mg po bid			All residents with pharmacy recommendations, agreed by ph will be reviewed and carried out	•	11/3/08	
ı		Consider adding or switching to itamin D (eg. Os-cal D) to of the calcium."			 Staff will be in serviced on proreviewing pharmacy recommend. Monthly consult audits will be 	dations.	11/3/08 11/3/08	
	The physician indica	nted under "Your Response - I al Vit D/Oscal BID[twice daily]."	•		Nurse Manager or designee and to Director of Nursing to present quarterly QI meeting.	d submitted	11/3/00	
	Facility staff failed to that the resident rec	clarify the order and ensure eived the Os-cal D twice daily.						
	Employee #5 on Sep He/she acknowledge	iew was conducted with otember 17, 2008 at 3:30 PM. ed that the resident had not The record was reviewed					.*	
		to follow up on a psychiatric ult for weight loss for Resident			6.) 483.25 QUALITY OF CARE1. Psych and Pharmacy consults completed for resident # 16.2. All residents identified for sign	nificant	9/17/08	
	" Psych Consult, P weight loss."	er dated June 16, 2008 directed, harmacy Consult secondary to			weight loss will be assessed and ordered will be done. 3. Staff will be reinserviced on the loss protocol and the important of the state of the sta	ne weight of		
	According to the recovers as as follows: February, 2008 123 March, 2008	ord, the Resident #16's weight 3.2 pounds 120.2		-	ensuring the Pharmacy, Dietary Speech consults are done. 4. Monthly weight loss audits will by Nurse Manager or designee a submitted to the Director of Nurs present in quarterly QI meeting.	II be done and	11/3/08	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING	∍		09/1	9/2008
	COVIDER OR SUPPLIER	REHAB		725	ET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	COMPLETION DATE
F 309	April, 2008 117 May, 2008 117 June, 2008 117 There was no evider psychiatric or pharm the time of this revie A face-to-face intervent Employee #7 on Septe He/she acknowledge pharmacy consults was reviewed Septe 7. Facility staff failed	7.8 7.8 2.8 nce in the record that the acy consults were completed at w. iew was conducted with otember 17, 2008 at 11:30 AM. ed that the psychiatric and vere not competed. The record	F 3		7.) 483.25 QUALITY OF CARE		
	An physician's interindirected, "Intermitter needed] and daily evanced A review of the Physigned August 5, 20 catheterization PRN inability to void". A review of the Intermedication Administ 2008 to September of the resident received record indicates the PRN. Additionally, the facil documentation of Ingresident at time of sunce in the resident at time of sunc	m order dated July 24, 2008 at catheterization PRN [as very HS [bed time]" sicians Order Sheet dated and 38 directed, "Intermittent at HS daily for sensation of disciplinary Note and the ration Records from July 21, 18, 2008 lacked evidence that if an In/out cath every HS. The resident did receive In/out caths but and Output records for this			1. Resident #28 catherization or changed to intermittent catherization of into void. 2. All residents were reviewed for catherization orders. There is one resident who does self catherization. Staff will be in serviced on implementary of the content of the con	ations ability or ne ations. portance of therization s. e done on flanager rector of	9/18/08 11/308 11/3/08

NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 728 BUCHANAN ST., NE PROPRETEX TAG PROPRETEX TAG PROPRETE ADDRESS, CITY, STATE, ZIP CODE 728 BUCHANAN ST., NE PROPRETEX TAG PROPRETEX TAG TAG PROPRETEX TAG PROPRETEX TAG TAG PROPRETEX TAG TAG PROPRETEX TAG		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
ARROLL MANOR NURSING & REHAB STREET ADDRESS. CITY, STATE, ZIP CODE 728 BUCHANN ST. D. 20017 (PAL) D. (PAL) D. (PACH DEPICIENCY WINTS RE PRECEDED BY FULL RESULATORY TAG CONTINUED FROM SIN OF DEPICIENCY WINTS REPRECEDED BY FULL RESULATORY TAG F 309 Continued From page 35 Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed or implemented by facility staff. The record was reviewed on September 18, 2008. 8. Facility staff failed to re-assess Resident S1 for pain during a wound treatment observation. A wound treatment observation. A wound treatment observation was not 10:15 AM. The resident was medicated at 9:30 AM with Tylenol in preparation for the wound treatment. The tape to the right ankle dressing was secured to the resident's Skin. While Employee #14 told Resident #1: "It's okay. The tape is almost off." Employee #14 failed to re-assess the resident's pain while removing the tape from the old dressing, Additionally, Employee #14 told Resident #1. "It's okay. The tape is almost off." Employee #14 failed to re-assess the resident's pain while removing the tape from the old dressing, Additionally, Employee #14 the decision while removing the tape from the old dressing change. Additionally, Employee #14 the decision while removing the tape from the old dressing change. He/she acknowledged that removing tape from the skin can be painful and would obtain an order from the physician to wrap Resident \$1's ankle with king gauze to secure the dressing and tape the gauze, thus avoiding placing tape directly on the resident's skin. 9. Facility staff failed to administer a nutritional supplement as per physician for Residents #4. Fig. JH1, JH3, JH5, and JH6 received correct dose of Beneprotein at the received correct dose of Beneprotein			095034	B. WING		09/1	9/2008
F 309 Continued From page 35 Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed or implemented by facility staff. The record was reviewed on September 18, 2008. 8. Facility staff failed to re-assess Resident S1 for pain during a wound treatment observation. A wound treatment observation was conducted on Resident S1's right ankle on September 16, 2008 at 10:15 AM. The resident was medicated at 9:30 AM with Tylenol in preparation for the wound treatment. The tape to the right ankle dressing was secured to the resident's skin. While Employee #14 was removing the tape from the old dressing, Resident S1 was grimacing and rapidly tapping the side rail with his/her index finger. Employee #14 fold Resident #1, "It's okay. The tape is almost off." Employee #14 failed to re-assess the resident's skin. A face-to-face interview was conducted with Employee #14 failed to initiate methods that would allow less painful removal of the tape from the resident's skin. A face-to-face interview was conducted with Employee #14 mandiately after the dressing change. He/she acknowledged that removing tape from the skin can be painful and would obtain an order from the physician to wrap Resident S1's ankle with kling gauze to secure the dressing and tape the gauze, thus avoiding placing tape directly on the resident's skin. 9. Facility staff failed to administer a nutritional supplement as per physician for Residents #6, JH1, JH3, JH5, and JH6.			REHAB	7	725 BUCHANAN ST., NE	,	
Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed or implemented by facility staff. The record was reviewed on September 18, 2008. 8. Facility staff failed to re-assess Resident S1 for pain during a wound treatment observation. A wound treatment observation was conducted on Resident S1's right ankle on September 16, 2008 at 10:15 AM. The resident was medicated at 9:30 AM with Tylenol in preparation for the wound treatment. The tape to the right ankle dressing was secured to the resident's skin. While Employee #14 was removing the tape from the old dressing, Resident S1 was grimacing and rapidly tapping the side rail with his/her index finger. Employee #14 told Resident#1, "It's okay. The tape is almost off." Employee #14 failed to re-assess the resident's pain while removing the tape from the old dressing, Additionally, Employee #14 failed to initiate methods that would allow less painful removal of the tape from the resident's skin. A face-to-face interview was conducted with Employee #4 immediately after the dressing change. He/she acknowledged that removing tape from the skin can be painful and would obtain an order from the physician to wrap Resident S1's ankle with king gauze to secure the dressing and tape the gauze, thus avoiding placing tape directly on the resident's skin. 9. Facility staff failed to administer a nutritional supplement as per physician for Residents #6, JH1, JH3, JH5, and JH6.	PRÉFIX	(EACH DEFICIENCY MUST	FBE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	
·	F 309	Employee #4 at app September 17, 2008 the order for intermicorrectly transcribed. The record was review. 8. Facility staff failed pain during a wound. A wound treatment Resident S1's right. 10:15 AM. The resident Tylenol in preparation of the resident's skin. removing the tape from the resident #1, "It's oken and the skin and the skin and the skin can be order from the skin can be order from the physical and the skin can be order from the physical and the skin can be order from the gauze, thus on the resident's skin.	proximately 4:00 PM on B. He/she acknowledged that tent catheterization was not dor implemented by facility staff. ewed on September 18, 2008. If to re-assess Resident S1 for different observation. Observation was conducted on ankle on September 16, 2008 at dent was medicated at 9:30 AM aration for the wound treatment. It ankle dressing was secured to While Employee #14 was from the old dressing, Resident and rapidly tapping the side railinger. Employee #14 told ay. The tape is almost off." If to re-assess the resident's pain ape from the old dressing. If the tape is the tape skin. The tape is almost off the tape is almost off. The tape is almost off the ta	F 309	8.) 483.25 QUALITY OF CARE 1. Order obtained to wrap ankle and secure with tape for resider 2. Resident with dressing change assessed for pain prior to and rethroughout the dressing changes 3. Staff will be in serviced on pafor dressing changes. 4. Monthly treatment competend done by wound nurse and subm Director of Nursing for presenting meeting for review. 9.) 483.25 QUALITY OF CARE 1. Resident # 6, JH1, JH3, JH5, received correct dose of Benepore	and JH6	11/3/08 11/3/08 10/9/08

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	095034	B. WING	<u>. </u>	09/19	9/2008
	REHAB	7	25 BUCHANAN ST., NE		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	(X5) COMPLETION DATE
Continued From page	ge 36	F 309	(con't from page 36)		
"Beneprotein [3] sco	pops two times daily po [by	. •	orders will be assessed for corre		11/3/08
The label on the outside of the Beneprotein container stipulated that [1] scoop is equal to			Staff will be in serviced on cormeasurements of Beneprotein p	owder.	11/3/08 10/9/08
During the morning medication passes, between September 16 and September 17, 2008, Employees #14, 24 and 25 administered the nutritional supplement, Beneprotein, with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6.			every six months. Results submi Nurse Manager and Director of I	itted to Nursing	10/9/08
September 18, 2008 11:15 AM with Empl employees acknowle administered incorre	6, at approximately oyees #4, 6 and 7. The edged that Beneprotein was ectly. The records were				
as per physician's or and JH5.	rders for Residents JH2, JH3		Order was obtained for pain m for resident # JH2 and administe	nedication ered.	9/16/08
A. Physician's order signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325 mg two (2) tablets for his/her pain.			will be reviewed to ensure there orders for pain medication. 3. Staff will be in serviced on imp	are oortance	11/3/08
			administering medication. 4. Med pass audits will be done every six months, results submit Nurse Manager and Director of N	on staff ted to Nursing	10/9/08
	Continued From page Physician's order sign "Beneprotein [3] scomouth] for low albur. The label on the outcontainer stipulated [1 ½] tablespoonful. During the morning September 16 and \$\frac{\pmathbb{H}}{2}\$ tablespoonful. During the morning September 16 and \$\frac{\pmathbb{H}}{2}\$ tablespoonful. A face-to-face interviewed in September 18, 2008 11:15 AM with Emplemployees acknowle administered incorrereviewed on Septem 2008. 10. The facility staff as per physician's order directed, "Acetamino mouth every 6 hours temperature." On September 16, 2 during the morning response was complaining of Employee #24 administered proposed to the propose to the proposed to th	O95034 ROVIDER OR SUPPLIER L MANOR NURSING & REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 Physician's order signed August 29, 2008 directed, "Beneprotein [3] scoops two times daily po [by mouth] for low albumin." The label on the outside of the Beneprotein container stipulated that [1] scoop is equal to [1 ½] tablespoonful of Beneprotein [powder]. During the morning medication passes, between September 16 and September 17, 2008, Employees #14, 24 and 25 administered the nutritional supplement, Beneprotein, with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6. A face-to-face interview was conducted on September 18, 2008, at approximately 1:15 AM with Employees #4, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications as per physician's orders for Residents JH2, JH3 and JH5. A. Physician's order signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325	Continued From page 36 Physician's order signed the nutritional supplement, Beneprotein, with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6. A face-to-face interview was conducted on September 18, 2008, at approximately 11:15 AM with Employees #4, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications as per physician's order signed August 10, 2008 directed, beneprotein incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications as per physician's order signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325	ROUNDER OR SUPPLIER L MANOR NURSING & REHAB SITREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017 PROVIDER OR JUNEAU ACTION SHOULD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 Physician's order signed August 29, 2008 directed, "Beneprotein [3] scoops two times daily po [by mouth] for low albumin." The label on the outside of the Beneprotein container stipulated that [1] scoop is equal to [1 ½] tablespoonful of Beneprotein [powder]. During the morning medication passes, between September 16, and September 17, 2008, Employees #14, 24 and 25 administered the nutritional supplement, Beneprotein, with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6. A face-to-face interview was conducted on September 18, 2008, at approximately 11:15 AM with Employees #4, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications as per physician's order signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass. Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325 mg two (2) tablets for his/her pain.	To complete the morning medication passes, between September 16 and September 17, 2008. Employees acknowledged that Beneprotein with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6. A face-to-face interview was conducted on September 18, 2008, at approximately 11.15 AM with Employees 44, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectity. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications as per physician's order signed August 10, 2008 directed, "A. Physician's order signed August 10, 2008 directed, "Complete the morning medication passes, between September 18, 2008, at approximately 11.25 AM with Employees 44, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medications and ministered incorrectly. The records were reviewed on September 16, and September 18, 2008. 10. The facility staff failed to administer medication so provided for pain medication for resident #14.24 and 2 september 18, 2008. 10. The facility staff failed to administer medications as per physician's orders signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10.00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325 mg two (2) tablets for his/her pain.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		COM	SURVEY LETED
		095034	B. WIN			9/19/2008
	ROVIDER OR SUPPLIER L MANOR NURSING 8	REHAB	.	7	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	A face-to- face inter approximately 10:07 He/she stated, "The administered to the employee telephone Acetaminophen to be were reviewed Sept B. Physician's order directed, "Megace 4 [orally] daily for appoint of the morning of JH3, Employee #25 Megace, instead of This observation was September 17, 2008 records were reviewed. C. Physician's order directed, "Acetaminophen 160 ml to Resident JH5. A face-to-face intervise September 19, 2008 Employee #4. He/sl Acetaminophen not	view was conducted at 7 AM with Employee #24. Acetaminophen was resident for mild pain." The ed the physician for se given for pain. The records ember 16, 2008. signed August 19, 2008 0 mg / ml administer 400 mg posetite stimulant." 2008, at approximately 10:15 AM medication pass for Resident administered 12.5 ml of 10 ml to Resident JH3. s reported to Employee #6 on 8 at approximately 3:30 PM. The red September 17, 2008. signed August 19, 2008 ophen 160 mg/5 ml, or tube twice daily for comfort." 008, at approximately 8:30 AM medication pass for Resident administered 20 ml of mg/5 ml liquid, instead of 20.3 iew was conducted on at approximately 4:40 PM with the acknowledged that was administered as per erecords were reviewed	F	309	10B.) 483.25 QUALITY OF CARE 1. Resident # JH3 received correct dose of Megace at next med pass. 2. All residents with liquid medication orders will be assessed for correct dosa measurement during med pass. 3. Staff will be inserviced on correct measurement of liquid medication. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing review at quarterly pharmacy and QI meeting. 10C-) 483.25 QUALITY OF CARE 1. Resident # JH5 received correct dose of Tylenol at next med pass. 2. All residents with liquid medications orders will be assessed for correct dosa measurement during Med pass. 3. Staff will be inserviced on correct measurement of liquid medication. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing review at quarterly pharmacy and QI meeting.	11/3/08 11/3/08 10/9/08 for 9/17/08 11/3/08 11/3/08 10/9/08
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/1	9/2008	
	ROVIDER OR SUPPLIER	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CO 725 BUCHANAN ST., NE WASHINGTON, DC 20017	· ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE	
F 309	Continued From page	је 38	F 30	09			
,	manufacturer's spec The physician's ordedirected, "Nexium 40	ed to administer medication per cification for Resident JH5. er signed August 5, 2008 0 mg capsule, [1] capsule per o[Gastroesophageal Reflux		11.) 483.25 QUALITY OF 1. Manufacturers specific during next med pass for 2. All residents with med requiring specific manufactions will be review to.	cation was followed r resident # JH5. ication orders acturers wed and adhered	11/3/08	
	for Nexium, stipulate the granules into a 6 Mix with 50 ml of wa shake the syringe w syringe with the tip u	nsert under patient information es "Open capsule and empty 50 ml catheter tipped syringe. ater. Replace plunger and ell for 15 seconds. Hold the up and check for granules in the granules if they have dissolved pieces"		 Staff will be in serviced manufacturers specificat medications administration. Med pass audits will be every six months, results Nurse Manager and Directive review at quarterly pharmageting. 	ions during on. e done on staff s submitted to octor of Nursing to	11/3/08	
	during the morning r JH5, Employee #14 [gastric tube]. He/sh medicine cup, add a	2008, at approximately 8:30 AM medication pass for Resident administered Nexium via g-tube ne opened the capsule into a approximately 5 ml of water then tube and flushed it with 5 ml of					
	September 19, 2008 with Employee #4. I Nexium was adminis	riew was conducted on B at approximately 12:00 PM He/she acknowledged that the stered as per manufacturer's ecords were reviewed B.					
F 314 SS=D		ehensive assessment of a must ensure that a resident who	F 31	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
•		095034	B. WING		09/1	9/2008
	COVIDER OR SUPPLIER	3. REHAB	•	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETION DATE
F 314	does not develop prindividual's clinical were unavoidable; a sores receives necepromote healing, prisores from develop. This REQUIREMENT Based on observati (2) of six (6) wound that facility staff faile wound dressing characteristics. The findings included 1. Facility staff failed during the dressing #8. A wound treatment September 16, 2006 Employee #15 wash that were removed to pocket. The employed and discharging it in receptacle. The word cleaned and a new Employee #15 processing in the cleaned dressing in the cleaned and the cleaned and the cleaned dressing in the cleaned were removed to the right 5th toe addressing in the cleaned and the cleaned and the cleaned and the cleaned and the cleaned dressing in the cleaned and the cleaned	ressure sores unless the condition demonstrates that they and a resident having pressure essary treatment and services to event infection and prevent new ing. It is not met as evidenced by: ons and staff interview for two treatments, it was determined ed to follow clean technique for anges. Residents #8 and S1.	F 3	1.) 483.25(c) PRESSURE So 1. Clean techniques were for dressing change for Reside 2. All residents identified with changes will be observed becare nurse to ensure clean are followed. 3. Staff will be in serviced of technique for wound dressing 4. Monthly random wound will be done by wound nurse Director of Nursing for presequanterly QI meeting	ollowed for next ent # 8. th dressing y the wound techniques on clean ng change. competencies e, submitted to	9/16/08 11/3/08 11/3/08 10/9/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/1	9/2008	
	ROVIDER OR SUPPLIER	REHAB	5	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETION DATE	
F 314	When the treatment disposed of the cleatrash receptacle loc. Employee #15 then room to wash his/he his/her hands at the During the dressing that Employee #15 tremoving and using pocket and not wash sink after discarding 2. A wound treatment on September 16, 2 S1. Employee #14 failed before placing 4 x 4 sterile saline and a the bag on top of the behads were in a plast opened and normal the gauze pads, while the gauze pads on top of failed to cleanse the sore in a circular module 2 x 2 gauze pads, leplaced them into the top of the wet 4 x 4 g. When the treatment	awas completed, Employee #15 ar plastic bag in the biohazard ated in the soiled utility room. returned back to Resident #8's er hands instead of washing a sink in the soiled utility room. change, there was no evidence followed clean technique by gloves from his/her uniform hing hands at the first available the soiled dressing. Int observation was conducted 008 at 10:15 AM for Resident did to wash off the bed side table gauze pads, a bottle of normal tube of Curosol gel in a plastic and side table. The 4 x 4 gauze this container. The container was sterile saline was poured onto ich were left in the container. Soiled dressing, Employee #14 by placing the saturated 4 x 4 of the wound twice. He/she a right ankle Stage II pressure often. Employee #14 opened the left them in the outer wrapper and at 4 x 4 gauze pad container on	F 3	2.) 483.25(c) PRESSURE S 1. Clean technique was fol dressing change for Reside 2. Clean technique was fol residents with dressing chats. Staff will be in serviced attechnique for wound dress 4. Monthly random wound will be done by wound nurs to Director of Nursing for p to quarterly QI meeting.	llowed for next ent # S1. llowed for all anges. on clean ing changes. competencies se, submitted	9/17/08 11/3/08 11/3/08 11/3/08	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/1	9/2008
	OVIDER OR SUPPLIER	REHAB	·	72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 314	bottle of normal steri	le saline from the room back	F	314	•		
		art. The soiled wound dressings ar plastic bag and disposed of sh.					
F 323 SS=D	The facility must ensenvironment remains is possible; and each	TS AND SUPERVISION sure that the resident sas free of accident hazards as a resident receives adequate stance devices to prevent	F:	323			
	This REQUIREMEN	T is not met as evidenced by:					
	review, it was detern maintain a safe envir residents as evidend burner with paper, m glass vases stored u covers in residents' r (Heating, Ventilation walking surface betweet medications left unathad multiple falls, on unauthorized leaves	in, staff interview and record in the that facility staff failed to ronment and supervise sed by: attempt to light the gas sultiple outlet strips on the floor, insafely, unsecured lamp rooms, unsecured HVAC and Cooling) unit covers, worn ween the parallel bars, stended, one (1) resident who see (1) resident who had of absence and one (1) multiple times. Residents #1, 2				,	
	The findings include:		·			•	
	Facility staff attemplece of paper.	pted to light a gas burner with a				-	
		e main kitchen on September nately 10:15 AM, the one (1)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/19	9/2008
	ROVIDER OR SUPPLIER	REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 323	#13 was asked what burner. Employee # paper located on the attempted to light the acknowledged that for lighting the gas is automatically light. 2. During the environ September 15, 2008 PM, mulit-plug outle floor in rooms 405, froom and the 1st floor cover in four (4) of cobservations were in Employee #23 who the time of the observations were in Employee #23 who the time of the observations were in September 15, 2008 PM, four (4) glass with the floor in room 314 walking path and on the top shelf above 64 rooms observed in the presence of Eacknowledged the floor in the presence of End observations. 4. During the environ September 15, 2008 PM, the ceiling lamp fixture in rooms 347 rooms observed. The presence of Employee #25 presence #25 pre	oven failed to light. Employee to method was used to light the standard to read to rea	F 323	1.) 483.25(h) 483.25(h) ACCIDEN' SUPERVISION 1. The Maintenance department was to immediately lite the burner. 2. All burners were inspected. 3. Employees attended a meeting of importance of notifying the Maintenato lite burners if they fail to lite. An invill be held on the proper procedure manager will monitor compliance. 4 Report monitoring results and coactions to the QI committee quarterly. 2.) 483.25(h) 483.25(h) ACCIDEN' SUPERVISION 1. All multi-plug outlets were secure. Walls and the covers were replaced. 3 Monitor the multi-plug outlets and coinspected, secured and covers replaneeded. 3 Monitor the multi-plug outlets and coinspected, secured and covers and take corrective action as 4 Report monitoring results and coactions to the QI committee quarterly. 3.) 483.25(h) ACCIDENTS AND SUPERVISION 1. Glass vases were immediately from room 314 and 510. 2. All residents rooms were checkled the property of the committen and superand will conduct environmental revery shift to ensure a resident senvironment. 4. Environmental rounds will be consisted and submitted to Director of quarterly for review in the quarter meeting.	n the ance dept. Inservice es. The arrective by. TS AND d to the acced where deced for deced for deced for deced for deced deced for deced dec	9/15/08 9/15/08 11/3/08 On-going 9/16/08 9/24/08 11/3/08 On-going 9/15/08 11/3/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		095034	B. WING	-		09/19	9/2008
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 323	September 15, 2008 PM, HVAC covers wand 523 in two (2) or observations were in Employee #23 who at the time of the observations the time of the observations are and skid strips were surface in one (1) of observed. These observed. These observed. These observed are observed to be observed to	nmental tour conducted on a from 8:45 AM through 8:20 were not secured in rooms 502 f 64 rooms observed. These hade in the presence of acknowledged the findings at rotations. Immental tour conducted on a from 8:45 AM through 8:20 face between the parallel bars in ea on the 3rd floor was worn not secured to the walking one (1) set of parallel bars servations were made in the wee ged the findings at the time of cation pass for Resident #6, 9:15 AM until 9:18 AM, and of the residents' medications art unattended to retrieve the medication room. At AM he/she left all the art to sanitize her hands in the determined to serve the findings at the time of the lerprion SR 100mg [1] tablet, apsule, Zinc 50 mg [1] capsule, I tablet, Cyclobenzaprine 10 mg odipine 10 mg [1] tablet, the finding 12.5mg [1] tablet, the Meclizine 1	F 3	23	4.) 483.25(h) ACCIDENTS AND SUPERVISION 1. The ceiling lamp covers were secured to the fixtures as required. 3 Monitor the condition of the ceiling covers and take corrective action as 4 Report monitoring results and corrections to the QI committee quarterly 5) 483.25(h) ACCIDENTS AND SUPERVISION 1. The HVAC covers were secured immediately. 2. All other HVAC covers were inspective actions as required. 3. Inservice staff on guidelines of Faccidents and Supervision. The HVAC will be monitored and corrective actions to the QI committee quarterly 6.) 483.25(h) ACCIDENTS AND SUPERVISION 1. The platform was cleaned and as Tape was removed. The platform will sanded in order to restore the surface Skid tape will be applied to the walking of the parallel bars in a perpendicula 2. An inspection of all training stair Bars, standing tables and any areas Antiskid support was performed from Thru 9/19/08. All areas showing evic Worn tape were replaced with new as 3. All physical therapy and occupated Safety risks that exist by not having the Surfaces secured. This topic will als Agenda item at the 10/31/08 Rehabil Services Staff Meeting, i.e., F-tag 32 Accidental and Supervision. 4. The Director will report monitoring And corrective actions to the QI quarterly accidents actions to the QI quarterly accidents and supervision.	inspected ed. ng lamp needed. rective y. ed ected and f-tag 323 AC covers on will be rective y. all worn lill be be New ng surface ar fashion. s, parallel requiring ng/16/08 dence of intiskid tape tional on the these of be an litation and results.	9/19/08 9/22/08 11/3/08 On-going 9/15/08 9/22/08 11/3/08 On-going
					Meeting.	terry	On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G	<u>· · · · · · · · · · · · · · · · · · · </u>	09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
F 323	Continued From pag	je 44	F	323	7.) 483.25(h) ACCIDENTS AND SUPERVISION		
	of the observation w	riew was conducted at that time rith Employee #24. He/she the medications were left on the ttended.			1. Employee # 24 was observed Med pass to ensure that medica not left on cart unattended. 2. All licensed staff will be obser Med pass to ensure that medical	ations were	9/16/08
		d to provide adequate re that Resident #1 did not leave nauthorized visitor.			not left on cart unattended. 3. Staff will be in serviced on me safety.		11/3/08
	Employee #10 on So He/she stated that the had concerns about #1 taking Resident possibility of having	riew was conducted with eptember 19, 2008 at 11:00 AM. he Interdisciplinary Team (IDT) Visitor #1 off the premise and the Resident #1 withdraw funds t using an ATM (Automatic			 4. Med pass audit will be done of every six months, results submit Nurse Manager and Director of review at quarterly Pharmacy armeeting. 8.) 483.25(h) ACCIDENTS AND SUPERVISION 1. As directed by the POA, Resi 	tted to Nursing for nd QI	11/3/08
	nephew/niece who li stated, "I spoke with Monday (August 11, concerns with [him/h me that it was okay [Visitor #1]. Howeve want [Visitor #1] to the facility."	onsible party was his/her lives out of state. Employee #10 of the responsible party on 2008) and shared our (IDT) her]. The responsible party told for [Resident #1] to visit with er, [responsible party] did not ake [Resident #1] out of the			not to leave the facility with unartisators. 2. All residents identified with vis restrictions will be reviewed with 3. Staff will be in serviced on LC 4. Resident LOA plan of care wireviewed at quarterly IDT confercare plan audits will be done and to Director of Nursing for present quarterly QI meeting.	sitor n staff. DA Policy. III be rence and d submitted	9/16/08 11/3/08 11/3/08
	order obtained from	physician orders revealed an Primary MD [Medical Doctor] "LOA [Leave of absence] with			·		
	indicated that the re- #1 on the following of August 14, 2008 fro	nce form for Resident #1 sident was signed out by Visitor days: om 1:20 PM - 3:20 PM m 5:10 PM - 6:30 PM					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		095034	B. WING	3 <u> </u>		09/19	9/2008
NAME OF PROVIDER	R OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	H DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
Augu Augu Augu Augu Augu Sept The supe the f The adec resic to as know facili	ust 18, 2008 froust 21, 2008 froust 22, 2008 froust 25, 2008 froust 2008 from 1008 from	m 1:30 PM - 3:10 PM m 12:25 PM - 2:00 PM m 4:30 PM - 6:10 PM m 12:45 PM - 2:15 PM m 2:15 PM - 3:30 PM m 1:40 PM - 2:30 PM 8 from 1:35 PM - 2:50 PM vidence that the facility provided re that Resident #1 did not leave or #1. put a process in place and se Resident #1 to prevent the g the facility with Visitor #1 and plicable staff are ut whom the resident can leave riew was conducted with eptember 19, 2008 at 0 AM. Employee #10	F3	323			
A rev follow June obse noted June bath discourse July report	wiew of the IDT wing: 22, 2008 at 19 erved slipping to d " 24, 2008 at 07 room on the floor of the 193, 2008 at 193, 2008 at 193	progress notes revealed the 20 (5:20 PM), "Resident was the floor no pain/injury was 30, "observed sitting in the or no complaint of pain or 30 (5:30 PM), "Charge nurse d to floor in bathroomno			9.) 483.25(h) ACCIDENTS AND SUPERVISION 1. Resident # 2 care plan was up reflect new intervention. 1. All residents fall risk indicatorisk action plan will be reviewed updated to reflect changes in the Interventions if necessary. 3. Staff will be in serviced regard updating Fall Risk Indicator Tool Action Plan after each fall to reflegoals for prevention of further on 4. Monthly fall audits will be done and submitted to Director of Nurreporting to quarterly QI meeting	r tools/fall and e current ling /Fall Risk ect current currences. e by Ql sing for	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	IG		09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB	•	7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 323	August 6, 2008 at 18 called at 1120 that the physical injury noted. A review of the "Fa action plan" revealed s/p [status post] fall updated with new action/approach s/p fall June 24, 200 new action/approach s/p fall July 23, 2008 new action/approach s/p fall August 6, 200 to the current plan of the curre	foo (3:00 PM), "This writer was the resident is on the floorno I" Ill risk indicator tool/Fall risk and the following: May 24, 2008 - plan of care etions/approaches 3- no new actions/approaches to are 8- plan of care updated with the second and the second actions approaches 6- plan of care updated with the second action plan" was completed and a fall on June 22, 2008. Ill risk indicator tool/Fall risk toonsistently updated/amended as identified as having a fall. Ince that after each fall the interventions to prevent the second at approximately 2:40 PM with the acknowledged that the plan #2 was not consistently the resident had a fall. The land second action of the second action of the second actions are resident had a fall. The land second action of the second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land second actions are resident had a fall. The land to follow the facility's policy	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	095034	B. WING		09/19	9/2008
	OVIDER OR SUPPLIER	REHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	,	
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F 323	The facility's Policy: Resident" revealed, is found, Communic resident and place in An observation of th lobby at approximate 2008 and on Septem 10:00 AM failed to re A face-to-face interv Employee #7 at the acknowledged that the resident at the recep will place it there impolicy was reviewed	#1207 titled "Elopement of A "Item #6"Once the resident ations will take a picture of the n the lobby." e receptionist's desk in the ely 6:30 PM on September 18, nber 19, 2008 at approximately eveal a picture of Resident #27. iew was conducted with time of the observation. He/she here was no picture of the otionist's desk. He/she added, "I mediately." The record and on September 19, 2008.	F 32	10.) 483.25(h) ACCIDENTS A SUPERVISION 1. Resident # 27's picture was the receptionist's desk. 2. All resident identified as e have their pictures placed at Receptionist desk. 3. Staff will be in serviced on policy. 4. Care plan audits will be do by Nurse Manager or design submitted to Director of Nurse presented to quarterly QI metals.	as placed at lopement risks the elopement one monthly ee and sing to be	9/19/08 11/3/08 11/3/08 11/3/08
F 332 SS=D	The facility must enserror rates of five per This REQUIREMEN Based on observation interview for three (3 observed during menthat facility staff did in rate less than five (5 pass. Residents JHZ) The findings include	T is not met as evidenced by: on, record review and staff of eight (8) sampled residents dication pass, it was determined not ensure a medication error percent during the medication 2, JH3 and JH5.	F 33	32		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	(X3) DATÉ SU COMPLET	
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F 332	free of a medication The medication erro based on the results observed on Septen opportunities were of significant errors. 1. The facility staff fa Acetaminophen as p Resident JH2. Physician's orders s "Acetaminophen (2) every 6 hours as need On September 16, 2 during the morning r was complaining of p Employee #24 admin mg two (2) tablets for A face-to-face interv approximately 10:07 He/she stated, "The administered to the r physician was teleph Acetaminophen to b The records were re 2. The facility staff fa per physician's order significants Physician's order significants	error rate of 5% or greater. In rate for the facility was 7.4% of the medication passes of the medication passes of the rate of and 17, 2008. 54 observed with four (4) non-mailed to administer over physician's orders for signed August 10, 2008 directed, tablets (650 mg) by mouth eded for elevated temperature." O08, at approximately 10:00 AM medication pass, Resident JH2 pain in the cheek area. In the cheek area of the pain. In the was conducted at the AM with Employee #24. Acetaminophen was resident for mild pain." The moned for a verbal order of the given for pain. The pain order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain. The moned for a verbal order of the given for pain.	F	332	1.) 483.25(m)(1) MEDICATION ER 1. Order was obtained for pain measurement of liquid medication 2. Staff will be in serviced on important obtaining physician orders prior to administering medication. 3. Staff will be in serviced on important obtaining physician orders prior to administering medication. 4. Med pass audits will be done of every six months, results submitted Nurse Manager and Director of Notes of the for review at quarterly pharmacy meeting. 2.) 483.25(m)(1) MEDICATION ER 1. Resident # JH3 received corresults with liquid medication orders will be assessed for corresults with liquid medication of the following medication	edication ered. dent prior cortance of o on staff ed to dursing and QI RRORS ect dose of ation ct dosage rect n. n staff ed to dursing for	9/16/08 11/3/08 11/3/08 10/9/08 9/19/08 11/3/08 11/3/08 10/9/08

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F 332	during the morning JH3. Employee #25 Megace, instead of The findings were reinterview which was 2008 at approximate The records were read. The facility staff facetaminophen as part of Resident JH5. A. Physician's order directed, "Acetaminophe 20.3 ml (650 mg) por Con September 17, 2 during the morning in	2008, at approximately 10:15 AM medication pass for Resident 5 administered 12.5 ml of 10 ml to Resident JH3. eported in a face-to-face conducted on September 17, ely 3:30 PM with Employee #6. eviewed September 17, 2008. alled to administer per physician's orders and manufactures recommendations	FS	332	3A.) 483.25(m)(1) MEDICATION 1. Resident JH5 received correction at next medication pass 2. All residents with liquid medication as will be assessed for correction measurement during medication 3. Staff will be in serviced on comeasurement of liquid medication 4. Med. pass audit will be done every six months, results submit Nurse Manager and Director of for review at quarterly pharmacy	et dose of cation ect dosage n pass. rrect on. on staff tted to Nursing	9/19/08 11/3/08 11/3/08 11/3/08
	ml to Resident JH5. A face-to-face intervision September 19, 2008 Employee #4. He/s Acetaminophen not physician orders. Th September 17, 2008 B. Facility staff failed manufacturer's specific physician's order.	riew was conducted on 3 at approximately 4:40 PM with the acknowledged that was administered as per the records were reviewed 3. If to administer medication per cification for Resident JH5. The resigned August 5, 2008 of mg capsule, [1] capsule per			meeting. 3B.) 483.25(m)(1) MEDICATION 1. Manufacturer's specification of followed during next med pass of #JH5. 2. All residents with medication requiring specific manufacturers instructions will be reviewed and to. 3. Staff will be in serviced on fol manufacturers specification during medication administration. 4. Med pass audit will be done of every six months, results submit Nurse Manager and Director of for review at quarterly Pharmacy meeting.	was for resident orders d adhered lowing ing on staff tted to Nursing	9/18/08 11/3/08 11/3/08 10/9/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 369 SS=D	tube daily for GERI Disease]." The manufactures for Nexium, stipulat the granules into a Mix with 50 ml of w shake the syringe with the tip tip. Do not give the or have broken into On September 17, during the morning JH5, Employee #14 [gastric tube]. He/s medicine cup, add poured it into the gwater. A face-to-face inter September 19, 200 with Employee #4. Nexium was admin specification. The reseptember 17, 200 483.35(g) DIETARY DEVICES The facility must preand utensils for reseptember 19 and utensils	insert under patient information tes "Open capsule and empty 60 ml catheter tipped syringe. ater. Replace plunger and vell for 15 seconds. Hold the up and check for granules in the granules if they have dissolved pieces" 2008, at approximately 8:30 AM medication pass for Resident administered Nexium via g-tube the opened the capsule into a approximately 5 ml of water then tube and flushed it with 5 ml of view was conducted on 8 at approximately 12:00 PM He/she acknowledged that the istered as per manufacturer's ecords were reviewed 8. Y SERVICES - ASSISTIVE Divide special eating equipment idents who need them. NT is not met as evidenced by: on, staff interview and record of 30 sampled residents, it was	F 36	483.35(g) DIETARY SERVICES ASSISTIVE DEVICES 1.Resident # 7 was assessed Speech Therapist and she det that Safe Swallow Guide and plate guard was no longer 2. All residents identified on a Swallow Guide will be reviewe	by the ermined needed. Safe d to ensure he e Swallow e audit will designee ursing to	10/8/08 11/3/08 11/3/08 11/3/08
	review for one (1) o				•	

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F 369	assistive device for The findings included A review of Resider Swallow Guide" da included the followir guard; assist reside manageable pieces clear mouth prior to liquids." The resident was of September 16, 2006 PM. The menu cons asparagus, fruit coo provided. There wa consumed all the fo without difficulty. A face-to-face interv Employee #4 on Se He/she stated, "(Re assistance or a plat discontinued this or reviewed on Septem 483.35(i) SANITAR' The facility must - (1) Procure food fro considered satisfact authorities; and	Resident #7 for meal time. It #7's record revealed, "Safe ted July 21, 2008. The guide ng: "Regular plate with plate nt with cutting food into small; resident should swallow and next bite; alternate solids and poserved at the lunch meal on a from 12:20 PM through 12:35 sisted of meatballs, spaghetti, ktail and milk. Water was also is no plate guard. The resident od followed by all the liquids wiew was conducted with ptember 16, 2008 at 1:00 PM. sident #7) no longer requires e guard. I should have der long ago." The record was not the record r	F 369	1.) 483.35(i) SANITARY CONDITION 1. The outside surfaces of the mixer, of Stove, outside surfaces of the tilt grill, Of the steam kettle, top surfaces of the Oven, compressor fan of the ice mach Outside of the convention oven, outside Popcorn maker, interior/exterior surface proper with grease build-up and the Supply lines and electrical wiring under Both fryers grease and debris, outside Dish machine by the detergent dispendant cleaned. 2 All surfaces were inspected and class needed. 3 All Food Service equipment will be on routine cleaning schedules. The De Director and the Quality Coordinator with monitor compliance and ensure clean 4 All cleaning schedules will be reviewed the Department Director. The Quality Assu Coordinator will visit the kitchen and inspect the equipment/kitchen areas every 10 days cleaning logs will be checked by the Qualit Coordinator for compliance. The Quality Cwill develop a monthly report. The findings report will be reviewed by the department as a plan of action will be developed for noncompliant items. A copy of this report is submitted to the Administrator monthly.	combi- outside e gas nine, de of ces of the he gas erneath e of the heser were leaned epartment vill liness. by irance cts s. All ty coordinator from this and	9/14/08. 11/3/08 11/30/08 On-going

AND PLAN OF CORRECTION Complete Complet	OLITICI	CO I OIN WILDIOMINE	A MILDIO/ND OLIVATOLO				CIVID NO	. 0000 0001
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ARROLL MANOR NURSING & REHAB MASHINGTON, DC 20017 TS SUCHANAN ST., NE MASHINGTON, DC 20017 TS SUCHAN ST., NE MASHINGTON, DC 20017 TS SUCHAN ST., NE MASHINGTON, DC 20017 TS SUCHANAN ST., NE TS SUCHANAN ST., NE MASHINGTON, DC 20017 TS SUCHAN ST., NE TS SUCHANAN ST., NE TS SUCHANAN ST., NE TS SUCHANAN ST., NE TS SUCHAN ST., NE TS SUCHANAN ST., NE TS SUCHAN ST., NE TS SUCHAN ST., NE TS SUCHANAN ST., NE TS SUCHAN ST., NE	i		095034	B. WIN	IG		09/19	9/2008
FREETIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG) F 371 Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: solied appliances, floor, grout, cove base, cooking hoods, undated/unlabeled foods in the freezer, walk-in refrigerator, cook's holding box and undated items in dry storage, thawing chicken improperly, hotel pans stored wet and ready for re-use, no monitoring of the three compartment sink, no air gaps for the cook's prep sink, drain cover unsecured, hand washing sinks with no trash cans, employee carrying food and floor mop at the same time, floor mop and sanitizer towels near food, transferring food into pan without gloves, hands not washed after returning to preparing food, brooms stored on the floor of the janitorial room, expired supplement and milk in the pantires, soiled transport care that wet plates ready for reuse. These findings were observed in the presence of Employees #13 and 21 on September 15, 2008 from 8:40 AM through 1. The outside surfaces of the following appliances were soiled with accumulated grease and debris: mixer, Combi-stove, outside surfaces of the gas oven, compressor fan of the ice machine, outside of the convection oven, outside of poporum maker, interior/exterior surfaces of the deep fryer with grease build-up and the gas supply lines and electrical wiring underneath both fryers grease and			REHAB	•	7	25 BUCHANAN ST., NE		
This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: soiled appliances, floor, grout, cove base, cooking hoods, undated/unlabeled foods in the freezer, walk-in refrigerator, cook's holding box and undated items in dry storage, thawing chicken improperly, hotel pans stored wet and ready for re-use, no monitoring of the three compartment sink, no air gaps for the cook's prep sink, drain cover unsecured, hand washing sinks with no trash cans, employee carrying food and floor mop at the same time, floor mop and sanitizer towels near food, transferring food into pan without gloves, hands not washed after returning to preparing food, brooms stored on the floor of the janitorial room, expired supplement and milk in the pantries, soiled transport cart and wet plates ready for resuse. These findings were observed in the presence of Employees #13 and 21 on September 15, 2008 from 8.40 AM through 11. The floor and grout between the floor time by the three (3) compartment sink, area undereds will be even inspected to the checked by the supervisors of cleanliness. 3. The supervisors of cleanliness. 3. The supervisors of cleanliness. 3. The supervisors of days. All cleaning logs will be checked by the Cuality undered by th	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD BE	CROSS-	(X5) COMPLETION DATE
dispenser, noncompliant items. A copy of this report will be submitted to the Administrator monthly. On-going	F 371	This REQUIREMEN Based on observation review, it was determatore, prepare, distrist sanitary conditions a appliances, floor, groundated/unlabeled for refrigerator, cook's in dry storage, thaw pans stored wet and of the three compart cook's prep sink, dry washing sinks with rocarrying food and floom pand sanitizer to food into pan without after returning to pretthe floor of the janitic and milk in the pantity wet plates ready for observed in the preson September 15, 20, 11:30 AM. The findings included 1. The outside surfactive were soiled with accomixer, Combi-stove, outside of the steam oven, compressor fathe convection oven interior/exterior surfagrease build-up and electrical wiring undedebris, outside of the steam oven, compressor fathe convection oven interior/exterior surfagrease build-up and electrical wiring undedebris, outside of the	ons, staff interview and record mined that facility staff failed to bute and serve food under as evidenced by: soiled out, cove base, cooking hoods, coods in the freezer, walk-in holding box and undated items ing chicken improperly, hotel I ready for re-use, no monitoring ment sink, no air gaps for the ain cover unsecured, hand no trash cans, employee for mop at the same time, floor evels near food, transferring at gloves, hands not washed eparing food, brooms stored on orial room, expired supplement ries, soiled transport cart and reuse. These findings were sence of Employees #13 and 21 cook from 8:40 AM through ces of the following appliances counties surfaces of the tilt grill, a kettle, top surfaces of the gas an of the ice machine, outside of , outside of popcorn maker, aces of the deep fryer with the gas supply lines and erneath both fryers grease and	F	371	1. The floor and grout between the floor tile throughout the kitchen, cove base and corners, walls by the grease trap, the dra by the three (3) compartment sink, the bar splash by the three (3) compartment sink, area underneath three (3) compartment sink area underneath three (3) compartment sink area under dish disposal were all clea 2. All other areas were inspected and cleas needed. The floor and wall areas will be placed on routine cleaning schedules and checked by the supervisors for cleanlines: 3. The supervisors will check to see if the kitchen areas have been clean and docun findings on the evening check list. 4. All cleaning schedules will be reviewed the Department Director. The Quality Assi Coordinator will visit the kitchen and inspethe equipment/kitchen areas every 10 day cleaning logs will be checked by the Quali Coordinator for compliance. The Quality will develop a monthly report. The findings report will be reviewed by the department a plan of action will be developed for noncompliant items. A copy of this report submitted to the Administrator monthly. 3.) 483.35(i) SANITARY CONDITIONS 1. The Hood filters were removed and cleanliness weekly. All unsatisfactory how will be cleaned. 3. Hood Filters will be placed on a routine cleaning schedule and check by the super 4. All cleaning schedules will be reviewed the Department Director. The Quality Assi Coordinator will visit the kitchen and inspet the equipment/kitchen areas every 10 day cleaning logs will be checked by the Quali Coordinator for compliance. The Quality (will develop a monthly report. The findings report will be reviewed by the department a plan of action will be developed for noncompliant items. A copy of this report will be reviewed by the department a plan of action will be developed for noncompliant items. A copy of this report	in ck ink, aned aned be s. nent I by urance ects ity Coordinator is from this and will be aned r ods rvisors. I by urance ects its. All ity Coordinator is from this and ity coordinator is from this and	On-going 9/14/08.

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F 371	the electric boxes a accumulated dust. 2. The floor and grothroughout the kitch soiled with accumulated that the grease trap, compartment sink, compartment sink, compartment sink, were observed soiled debris. 3. Seven (7) of seve soiled with accumulated with accumulated with accumulated by the grease of soiled with accumulated with accumulated by the grease of seven (7) of seve soiled with accumulated by the grease of seven (8) of seven (9) of seve soiled with accumulated by the grease of conditions of soiled of scones, and 4 packages of chopper container of sliced or plastic container, 1 batter, 1 box bluebes shredded lettuce, or and 135 Strawberry marked on the side thawing, keep refrigithawing."	on top of the dish machine, and bove the dish machine with but between the floor tiles aren, cove base and corners were ated debris and grease. Walls the drain by the three (3) the back splash by the three (3) area underneath three (3) and area under dish disposal and with accumulated grease and area dust, grease and debris. The provided History of the disposal area area area area area debris. The provided History of the provided His	F 37	1 4 483.35(i) SANITARY COND 1. All unlabeled and undated item Immediately dated and the ones to labeled were discarded. 2. All opened food items in the stowere inspected and labeled. 3. Supervisors will check storage see if foods items are properly lab in-service on properly labeling food be given by the Food Service Dired. The Quality Coordinator will visk itchen every 10 days to check conduction will be developed noncompliant items. This report we submitted to the administrator most.) 483.35(i) SANITARY CONDITION 1. The water was removed from the 1. All trays were inspected to ensidery. The supervisors will monitor the thawing procedures in the kitch correct if necessary. 3. An in-service on proper thawing will be given by the Food Service 4. Quality Assurance Coordinator of the kitchen every 10 days for comfindings will be reviewed with the land a plan of corrections will be dononcompliant items. This report we the Administrator monthly. 6.) 483.35(i) SANITARY CONDITION 1. The celery was immediately discusted or returned to the seller 3. All produce was inspected for appearance. All unsatisfactory prodiscarded or returned to the seller 3. All produce will be checked dail supervisors for a satisfactory appearance. All findings will be reviewed planer. The given to the Administrator monthed the Administrator monthed planer.	s were hat could not orage areas daily to peled. An id items will ector, sit the impliance. Department ed for ill be inthly. DITIONS awed trays, ure they were closely hen and items Director, will inspect pliance. All Department evelop for ill be given to	9/16/08 10/25/08 9/16/08 ????	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 371	on two (2) trays who mix were stored, wit cartons one tray in the first on stalks and refrigerator. 7. Items in the dry solutions of the two (2) cook with chicken parts the with ice. 9. The following hot greasy residue and Nine (9) 1/3 hotel pans, 17 hotel pans. 10. There was no ensanitizer and water sanitizer and water sanitizing were more compartment sink. 11. There were no a valves for the two (2) the drain cover was not secured and 13. The designated	2 inches of water accumulated ere cartons of scrambled egg th 13 cartons on one tray and 10 the walk-in refrigerator. bunches of celery with brown wilted leaves in the walk-in torage area were undated. Is preparation sinks were filled that were thawing and covered el pans were stored wet with a	F	371	1.All items in the dry storage contain labeled and dated immediately. 2. Supervisors will check all dry stora and label all unlabelled items. 3.A daily walk through of the dry stor by the supervisors will done to monicompliance 4. The Quality Assurance Coordinato inspect the kitchen every 10 days for compliance. All findings will be review the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly 8.) 483.35(i) SANITARY CONDIT 1. The cook was immediately instruct regarding proper thawing techniques chicken parts were immediately disc. 2 The area was inspected to ensure other chicken parts were thawing, coice. All cooks were instructed on prohandling of thawing techniques. 3. In-services were given to staff by Services Director. 4. The Quality Assurance Coordinate inspect the kitchen every 10 days for compliance. All findings will be review the Department and a plan of correct be develop for noncompliant items. It will be given to the Administrator mo. 9.) 483.35(i) SANITARY CONDIT 1. The entire rack of pans were immedianed by the dish machine. 2 All pots and pans were inspected Cleaned on the hotel pan rack, as not an inspect the kitchen every 10 days for compliance. All findings will be review the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This be given to the Administrator monthly the Department and a plan of correct develop for noncompliant items. This	age areas rage areas rage areas rage areas rage areas record will record will record and the record in record in record will r	9/15/08. 9/27/08 10/25/08 9/15/08.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING	-		09/19	9/2008	
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFI	CROSS-	(X5) COMPLETION DATE	
F 371	hotel pans of cooked floor mop in other. against the counter occunter. 15. The floor mop was ink by the cook's probeing prepared. 16. Employee #19 w	ras observed carrying two (2) d hamburgers in one hand and a The employee laid the mop while placing meat on same as observed leaning against reparation area where food was ras observed carrying the floor	F3	71	10.) 483.35(i) SANITARY CONDITIO 1. The water was tested using test str proper pH and documented. 2. All testing documentation will be plated the pH testing log and monitored by s 3. An in-service is scheduled by ECC 4. The Quality Assurance Coordinator inspect the kitchen every 10 days for compliance. All findings will be review the Department and a plan of correcting develop for noncompliant items. This be given to the Administrator monthly 11.) 483.35(i) SANITARY CONDITION.	rips for aced on supervisor. DLAB. r will ved with ons will be report will	9/15/08. 10/27/08. 10/25/08	
	mop towards the wa area where food was 17. Sanitizer towels	lk-in refrigerator through the s being prepared. were sitting open on counter spaghetti were located and			1. Maintenance was contacted an Flow valve was installed immediat 2 All other sink areas were inspecorrected as needed. This will be monitored by supervisors. 3. Results will be submitted to the	d a back tely. ected and	9/22/08	
	from a cooking to se approximately 10:50 19. Employee #21 w	as observed filling dessert			 4. A report will be presented quarthe QI committee. 12.) 483.35(i) SANITARY CONDITION 1. The drain cover was cleaned. 2 All other drains were inspected and as needed. This is monitored by supe 	IONS d cleaned	On-going 9/15/08.	
	removing one (1) glo from his/her ID holde did not wash hands returned to filling the	e employee was observed ove, retrieved a sanitation card er, handed it to supervisor, and before replacing glove and edessert dishes. and two (2) push brooms were			3. An in-service will be given by Direct 4. The Quality Assurance Coordinator inspect the kitchen every 10 days for compliance. All findings will be review the Department and a plan of correctibe develop for noncompliant items. The will be given to the Administrator mon	ctor. r will ved with ons will his report	10/27/08. On-going	
	observed on floor of kitchen.	janitorial closet in the main were acknowledged by			13.) 483.35(i) SANITARY CONDITION 1. The lidless trash cans were placed by significant employee rewashed their hands. 2 All employees instructed to use lidless trash after washing their hands. This is	ink and the	9/15/08	
	Employee #13 at the 21. Nine (9) of nine (e time of the observations. (9) cans of Nepro supplement the of April 1, 2008 in the 3rd			monitored daily by supervisors. 3. In-service scheduled by Director. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be given to the Administrator monthly.	will	10/27/08. 10/25/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING	·		09/1	9/2008	
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017	3071	57 2 505	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE	
F 371	floor pantry. 22. Four (4) of four ((1) of five (5) cartons date of September 1 and seven (7) of 11 expiration date of Se floor pantry.	ge 56 4) cartons of skim milk and one s of whole milk with expiration 2, 2008 in the 3rd floor pantry cartons of skim milk with an eptember 12, 2008 in the 5th art observed soiled and with a	F 3	71	14.) 483.35(i) SANITARY CONDI 1. The cooked hamburgers were the The employee was immediately cor 2 All employees were instructed by service Director about preventing crontamination. 3. An in service will be given by Food Director on preventing cross contain 4. The Quality Assurance Coordinatinspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of corrections.	rown away. rected. y the Food ross od Service nination. tor will or ewed with	9/15/08 9/27/08	
F 386 SS=E	cracked top shelf in 24. 19 of 42 dinner p for reuse in the 1st fl 483.40(b) PHYSICIA	the 1st floor pantry. blates observed wet and ready loor pantry. NN VISITS	F 3	86	be develop for noncompliant items. will be given to the Administrator mo 15.) 483.35(i) SANITARY CONDI 1. The mop was removed and area 2. The cooks were instructed by the Director of the importance of prever cross contamination.	This report onthly. TIONS sanitized. Food Svc.	10/25/08 9/14/08	
	program of care, inc treatments, at each of this section; write at each visit; and sig exception of influent polysaccharide vaccadministered per physical	review the resident's total luding medications and visit required by paragraph (c) sign, and date progress notes in and date all orders with the a and pneumococcal ines, which may be ysician-approved facility policy for contraindications.			3.An in service will be given by Foo Director on prevention of cross cond 4. The Quality Assurance Coordinate inspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. will be given to the Administrator model.) 483.35(i) SANITARY CONDITION.	tamination. or will or ewed with ctions will This report onthly. ITIONS another path	9/27/08 10/25/08	
	Based on observation for seven (7) of 30 s	T is not met as evidenced by: on, interview and record review ampled residents, it was physician failed to review the			 All staff were instructed to take a outside of the prep areas to prevent contamination. An in service will be given on p cross contamination by Food Servic 4 The Quality Assurance Coordinate inspect the kitchen every 10 days for the contamination of the co	nother path t cross revention of the Director. or will or	9/16/08 9/27/08	
1	total plan of care for the current advance	six (6) residents and include d directive on the history and ne (1) resident. Residents #2, 6.			compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. will be given to the Administrator model. 17.) 483.35(i) SANITARY CONDITION 1. Sanitizer towels were removed for preparation area and the food preparation.	ctions will This report onthly. TIONS om food	10/25/0	
					was cleaned with a sanitizer.		9/19/08	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SUP	
AND FEMALES	- CORRECTION	DENTIFICATION NOMBER.	A. BUIL	LDING	3	COMPLET	ED
	·	095034	B. WIN	.G		09/1	9/2008
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		-
CARROL	L MANOR NURSING	& REHAB			25 BUCHANAN ST., NE		
				V	WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BIT REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 386	Continued From pa	age 57	F;	386	(con't from page 57)		
	_	led to review the total plan of care	-		17.) 483.35(i) SANITARY CONDITIONS		
	for the following res		*		2. Food Service Director instructed s Prevention of food contamination on		,
					3. An in- service will given by Food Serv		10/11/08
		ailed to include falls in the plan of		.	4 The Quality Assurance Coordinator will		1.4.
		n of care was reviewed for	•		inspect the kitchen every 10 days for	***	
	Resident #2 who h	nad multiple falls without injury.			compliance. All findings will be reviewed the Department and a plan of corrections		
					be develop for noncompliant items. This		
		[interdisciplinary team] progress			will be given to the Administrator monthly	y.	10/25/08
	notes revealed the	following:			18.) 483.35(i) SANITARY CONDITIONS 1. The associate was instructed to wear		
	luna 22, 2009 at 1	2000 "Bosidont was observed			when handling ready to serve foods.	gioves	9/19/08
		920, "Resident was observed r no pain/injury was noted"			2. All employees were instructed by Foo		** · ** · · ·
	lune 24 2008 at 0	0730, "observed sitting in the			Director to wear gloves when handling re		
		oor no complaint of pain or			foods. This is monitored daily by supervise. 3. An in service will be given to staff by I		10/11/08
	discomfort."	301 110 dompiant of pain of			4 The Quality Assurance Coordinator will		10/11/00
		930, "Charge nurse reported			inspect the kitchen every 10 days for		
		or in bathroomno apparent			compliance. All findings will be reviewed the Department and a plan of corrections		
	injuries"				be develop for noncompliant items. This		
		1500, "This writer was called at			will be given to the Administrator monthly	y.	10/25/08
		lent is on the floorno physical			19.) 483.35(i) SANITARY CONDITIONS		
	injury noted"				Employee was instructed by Director to hands immediately and change gloves.	o wasn	9/15/08.
	T':	- 11-as that the attaching			2. All employees were instructed on prop	er usage	3713703.
		evidence that the attending			of gloves when preparing foods.	_	
	physician reviewed	d the resident's fall status.			An in service will be given by Food Sv on proper usage of gloves when handling		9/27/08.
	A face-to-face inter	rview was conducted on			4 The Quality Assurance Coordinator will		9121100.
		08 at approximately 2:40 PM			inspect the kitchen every 10 days for	ſ	
		she acknowledged that the			compliance. All findings will be reviewed the Department and a plan of corrections		
,		n failed to include the falls in the			be develop for noncompliant items. This		
		of care. The record was reviewed			will be given to the Administrator monthly	<i>i</i> .	10/25/08
	on September 16, 2	2008.		ļ	20.) 483.35(i) SANITARY CONDITIONS		
					1. All brooms were immediately hung in to closet.	ne jamionai	9/15/08
		ident #4's record revealed the			2Supervisors will monitor daily to see if	the brooms	
		notes: May 27, 2008 at 1100 "			are hung properly in the janitorial closet.		
		th a dry scab over the right			3. An in-service will be given on the imp hanging broom properly in the closet by t		10/11/08.
	gluteus area"				4. The Quality Assurance Coordinator will		10/11/00.
	The resident's weigh	ght in March 2008 was 166.4		ĺ	inspect the kitchen every 10 days for		
		/ 2008 was 157.2 pounds. The			compliance. All findings will be reviewed the Department and a plan of corrections		
	pourius aria irriviay	2000 was 107.2 pounds. The			be develop for noncompliant items. This		
		•			will be given to the Administrator monthly		10/25/08

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IPLE CONSTRUCTION	ON (X3) DATE SURVEY COMPLETED	
			A. BUILDIN	IG		
		095034	B. WING _		09/1	9/2008
	OVIDER OR SUPPLIER	REHAB		REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386	Physician #1's note	inds in two (2) months.	F 386	21.) 483.35(i) SANITARY COND 1. All expired Nepro cans were disc 2 The pantries were inspected and cans were discarded. This is monit Supervisors.	carded. d all expired ored daily by	9/16/08
••	reviewed and signed physical exam unch present meds and tr	d; vital signs stable, afebrile; anged; plan stable, continue		3. Food Service Director instructed importance of discarding expired state. The Quality Assurance Coordinatinspect the kitchen every 10 days frompliance. All findings will be revited be pertaged.	upplements. ator will or ewed with	9/27/08
	condition and weigh	t loss.		be develop for noncompliant items. will be given to the Administrator m 22.) 483.35(i) SANITARY COND	This report onthly.	10/25/08
	Physician #1 on Sep He/she acknowledge the resident's status	otember 15, 2008 at 10:30 AM. ed that the note did not reflect . The record was reviewed		All expired milk was discarded in 2 All pantries were inspected and milk was discarded. This is monitor 3. An in-service was given to staff	mmediately. all expired ed daily.	9/16/08 9/27/08
	following nurses' not July 2, 2008 at 1300 at the same table' July 3, 2008 at 0630	lent #7's record revealed the tes: , "Resident hit another resident", "Resident was confused		4. The Quality Assurance Coordinatinspect the kitchen every 10 days for compliance. All findings will be revited the Department and a plan of corresponding to the develop for noncompliant items will be given to the Administrator materials.) 483.35(i) SANITARY COND	ator will or ewed with ections will . This report nonthly.	10/25/08
	clothes off. Also thro	natter and taking [his/her] wing pillows and sheets"		The food transport cart and tray discarded. All food trays and carts were in	were	9/15/08
	Employee #4 on Sep He/she stated," The resisting care, but in	iew was conducted with otember 16, 2008 at 1:00 PM. resident had moments of July (2008) [he/she] had a ally bizarre behavior."		cleaned as needed. This is monitor 3. Staff instructed by Director to us with prepared food. 4. The Quality Assurance Coordina inspect the kitchen every 10 days for compliance. All findings will be revi	red daily. se clean carts ator will or	9/27/08
	April 114 pounds May109 pounds June 106.4 pound	ds		the Department and a plan of corre be develop for noncompliant items. will be given to the Administrator m 24.) 483.35(i) SANITARY COND	ections will This report onthly.	10/25/08
		dated July 3, 2008,"Patient l, vital signs stable, afebrile,		 The employee was instructed to the wet plates and to use dry plates All dinner plates were inspect dried as needed. This is monitore All employees were instructed to plates during meal service. 	s only. cted and d daily	9/19/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095034	B. WIN	G		004	0/0000
NAME OF DE	ROVIDER OR SUPPLIER			0.7.0	EET ADDEEDS OUT OTATE TO SODE	09/1	9/2008
	L MANOR NURSING	& REHAB		7:	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 386	chart/orders revie BUN/CR 63/1.4, Usencourage increa Physician #1 faile change in behavior reviewed Septem D. A review of Respeech therapist' (1:30 PM):" Patiprofound oral-phacontrol" The resident recelanguage therapis 26, 30 and July 1, On July 6, 2008 and described a right According to Physician #1 faile dysphasia and neuron physician #1 faile dysphasia and neuron July 16, 2008, tube. According to August 12, 2008, chart/orders revie afebrile, physician #1 faile present orders and Physician #1 faile	wed and signed, latest lab - JA pending, volume depletion, sed fluids, awaiting U/A." d to address the resident's sudden or and weight loss. The record was ber 16, 2008. sident #10's record revealed a s note dated July 25, 2008 at 1330 ent presents with a severe- ryngeal dysphasiapoor oral eived therapy from the speech of for dysphasia on June 17, 25, 2, 4, 5, and 7, 2008. It 2110 (9:10 PM), a nurse's note buttocks pressure sore. sician #1's note dated July 8, aus, chart/orders reviewed and thysical exam unremarkable, resent meds and treatment." If to address the resident's why developed pressure sore. The resident received a feeding of the physician's note dated (Patient without distress, wed and signed, vital signs stable, exam unchanged, stable, continue d treatment." If to address the resident's newly be. The record was reviewed	F3	386	4. The Quality Assurance Coordinatinspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. Will be given to the Administrator moderate and the province of the Administrator moderate and the province of the Administrator moderate and the province of the Administrator moderate and include the falls. 2. The physicians will review all of the resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident and the physicians on their responsibility to reside the physicians on their responsibility to reside the physicians of correct of the Administrator summarizate and the physicians and the properties of the Administrator summarizate and the physicians who failed to meet requirement will review the total plan resident and the physicians will review all of the resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident's plans of correction to insucompliance will be prepared for Medical 4. The Medical Director will correct prompliance as needed and submit a report to the Administrator summarization for compliance as needed and submit a report to the Administrator summarization for compliance as needed and submit a report to the Administrator summarization for compliance as needed and submit a report to the Administrator summarization for compliance as needed and submit a report to the Administrator summarization for compliance.	tor will r wed with ctions will This report onthly I this n of care for eir re all attending review the will be physician Monthly Director. hysician a quarterly zing plans corrective I this n of care for ndition eir re all attending review the will be physician n of care for ndition eir re all attending review the will be physician for care in dition eir re all attending review the will be quarterly zing plans	10/25/08 11/308 11/3/08 On-going
					reviewed, rates of compliance and c actions taken or required	orrective	On-going

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SUF COMPLET	
		095034	B. WIN		,	09/1	9/2008
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 386	E. A review of Resideresident's weight for June 135 pour July 129 pounds August 125.3 pour Hospice care was in	dent #13's record revealed the r 2008 as follows: ands	F	386	1C. 483.40(b) PHYSICIAN VISIT 1. The physicians who failed to meet requirement will review the total plan resident # 7 and include the change behavior and weight loss. 2. The physicians will review all of the resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident.	this n of care for in eir re all attending	11/3/08
·	2, 2008, "Patient with reviewed and signed physical exam uncha and treatment."	cian #1's note dated September hout distress, chart/orders d, vital signs stable, afebrile, ranged, continue present meds to address the resident's			total Plan of Care. Monthly audits w conducted by facility staff to monitor visit documentation for compliance. reports will be prepared for Medical I 4. The Medical Director will correct pl compliance as needed and submit a report to the Administrator summariz reviewed, rates of compliance and co	rill be physician Monthly Director hysician quarterly zing plans	11/3/08
	record was reviewed	d September 19, 2008. dent #16's record revealed the r 2008:			actions taken or required. 1D. 483.40(b) PHYSICIAN VISIT 1. The physicians who failed to meet requirement will review the total plar resident # 10 and include the feeding 2. The physicians will review all of the resident's plans of correction to insu compliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to restal Plan of Care. Monthly audits w	this n of care for g tube. 11/3 eir re all attending review the	
	2008,"Patient withou reviewed and signed physical exam patien TSH/T4 -0.01/0.88.	tian #1's note dated July 10, but distress. Chart/orders d, vital signs stable, afebrile, and remains asymptomatic with Continue to monitor for signs ypothyroidism, continue present ts."			conducted by facility staff to monitor visit documentation for compliance. reports will be prepared for Medical 4. The Medical Director will correct pl compliance as needed and submit a report to the Administrator summariz reviewed, rates of compliance and cactions taken or required.	physician Monthly Director. hysician quarterly zing plans	11/3/08 On-going
		to address the resident's weight as reviewed September 17,		·	actions taken of required.		On-going
							•

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED						
					· · · · · · · · · · · · · · · · · · ·		
		095034	B. WINC	<u> </u>		09/19	9/2008
	ROVIDER OR SUPPLIER L MANOR NURSING &	k REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NÉ VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 386 F 406 SS=D	2. Upon completing Resident #5's the ph program of care. A review of the Adm Examination form concevidence that the Adm Examination section A face-to-face interv September 18, 2008 #6. He/she acknowl incomplete. The recompletember 18, 2008 483.45(a) SPECIALISERVICES If specialized rehability is the program of the pro	the history and physical form for hysician failed to review the total nission and Annual Physical completed April 9, 2008 lacked dvance Directives and Physical ns were completed. View was conducted on 8 at 11:30 AM with Employee redged that the H&P form was cord was reviewed on	F 3	386 406	1. The physicians who failed to meet requirement will review the total plan resident # 13 and include the admiss hospice and weight loss. 2. The physicians will review all of the resident's plans of correction to insurcompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to resident Plan of Care. Monthly audits we conducted by facility staff to monitor visit documentation for compliance, reports will be prepared for Medical 4. The Medical Director will correct plant compliance as needed and submit a report to the Administrator summarizareviewed, rates of compliance and cactions taken or required. 1F. 483.40(b) PHYSICIAN VISIT	this n of care for sion to eir all attending review the rector. The rector is a quarterly zing plans corrective	11/3/08 11/3/08
	pathology, occupation rehabilitative services retardation, are required comprehensive plan provide the required services from an out with §483.75(h) of the specialized rehabilitation. This REQUIREMEN Based on record rev (1) of 30 sampled repeabilitation staff definitions.	onal therapy, and mental health es for mental illness and mental uired in the resident's in of care, the facility must ill services; or obtain the required tiside resource (in accordance his part) from a provider of ative services. IT is not met as evidenced by: view and staff interview for one esidents, it was determined that elayed service to Resident #10.			1. The physicians who failed to meet requirement will review the total plan resident # 16 and include the weight 2. The physicians will review all of the resident's plans of correction to insuccompliance with this requirement. 3. The Medical Director will educate a physicians on their responsibility to rotal Plan of Care. Monthly audits we conducted by facility staff to monitor visit documentation for compliance, reports will be prepared for Medical 14. The Medical Director will correct ple compliance as needed and submit a report to the Administrator summarize reviewed, rates of compliance and contact actions taken or required.	n of care for t loss. eir all attending review the rill be physician Monthly Director. hysician quarterly zing plans	11/3/08 11/3/08 11/3/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095034	B. WING		· ·	09/19/2008	
	OVIDER OR SUPPLIER	& REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE (ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE O REFERENCED TO THE APPROPRIATE DEFI	CROSS-	(X5) COMPLETION DATE
F 425 SS=D	2008 directed, "Spe The initial evaluation 2008, with addition." The treatment bega after the initial evaluation. A face-to-face inter Employee #22 on J He/she stated, "It' within 72 hours of ratherapist left at the began about two waspeech therapist so first and then started anyone to do the the September 17, 200 483.60(a),(b) PHAF The facility must produge and biological under an agreement part. The facility must provided and the general so A facility must provided including procedural acquiring, receiving of all drugs and biological the general solution. The facility must endicensed pharmacis	eech evaluation." In was conducted on June 17, all orders to treat for dysphasia. In June 25, 2008, seven (7) days uation. View was conducted with une 17, 2008 at 5:30 PM. so our policy to evaluate and treat ecciving the order. A speech end of May (2008) and another eeks later. The newly hired treened the back log of residents d therapy. We just didn't have erapy." The record was reviewed 8.	F 4		2. 483.40(b) PHYSICIAN VISIT 1. The physicians who failed to meet the requirement will review the total plant of resident #5 and the advanced directive physical examination sections. 2. The physicians will review all of their resident's plans of correction to insure compliance with this requirement. 3. The Medical Director will educate all physicians on their responsibility to restotal Plan of Care. Monthly audits will conducted by facility staff to monitor possit documentation for compliance. We reports will be prepared for Medical Disconducted Disconducted Director will correct physicompliance as needed and submit a greport to the Administrator summarizing reviewed, rates of compliance and conductions taken or required. 483.45(a) SPECIALIZED REHABIL SERVICES 1. The resident in question was treat Discharged from skilled speech and last Services. 2. All Carroll Manor Speech and Lar Orders between 5/19/08 and 6/16/08 or Reviewed and inspected for compliant Treatment orders. 3. The current system for the receipt Orders at Carroll Manor will be changed Order for CM staff to receive orders did This topic will also be an agenda item 10/31/08 Rehabilitation Services Staff A Daily "run report" will be inspected in To identify residents that have Rehabilorders. A weekly inspection of the "receive Residents that were treated by CM-Residents that were treated by CM-Residents that were treated by CM-Residents and corrective actions to the Complex of the Co	of care for the and the angular of the angular o	11/3/08 On-going
					Committee quarterly.		11/3/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WING	;		09/19/2008	
	ROVIDER OR SUPPLIER	REHAB	,	725	ET ADDRESS, CITY, STATE, ZIP CODE 5 BUCHANAN ST., NE ASHINGTON, DC 20017	,	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	3	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 425	Continued From pag	ge 63	F 4:	25			
	Based on record rev (1) supplemental res the facility staff failed administration of a control of the June, July and August Administration Record The findings include The April 1 through Sheet signed by the directed, "Lorazepar hours as needed for The May 2008 MAR with signatures that three (3) times, May initials entered in the mentioned. The "Controlled Druborazepam was admin May 17 (1030 & 1) There was no evider the Lorazepam was and 23. The June1 through Sheet signed by the directed, "Lorazepar hours as needed for The June 2008 MAR	ontrolled substance on the May, ast 2008 Medication and (MAR) for Resident JH7. May 31, 2008 Physician's Order physician on April 4, 2008 and 1mg tablet by mouth every 8 severe agitation. was reviewed and indicated Lorazepam was administered 17, 19 and 22, as evidence by a allotted areas for the dates. In Record indicated the ninistered on the following dates 800), 19, 22 and 23 2008. The control on May 17 (1800). Italy 31, 2008 Physician's Order physician on June 19, 2008 and 1mg tablet by mouth every 8.		\$ 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	483.60(a),(b) PHARMACY SERV 1. Next dose of Lorazepam admi was signed in MAR for resident in the control of the documentation on the MARs complete. 3. Staff will be in serviced on me protocol. 4. Med pass audit will be done of every six months, results submit Nurse Manager and Director of its for review at quarterly pharmacy meeting.	nistered # JH7. ntrolled nsure were d pass n staff ted to Nursing	9/18/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
095034 B. WING	
NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB STREET ADDRESS, CITY, STATE 725 BUCHANAN ST., NE WASHINGTON, DC 200	E, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE	PLAN OF CORRECTION E ACTION SHOULD BE CROSS- IE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 425 Continued From page 64 seven (7) times, June 1, 3, 4, 9, 19, 20 and 22 as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following dates in June 1, 3, 4, 9, 12, 19, and 22, 2008. There was no evidence on the June 2008 MAR that the Lorazepam was administered on June 12 and 20. The July 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered two (2) times, July 3 and 27, as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following dates in July 3,13,14 and 27, 2008. There was no evidence on the July 2008 MAR that the Lorazepam was administered on July 13 and 14. The August 1 through September 30, 2008 Physician's Order Sheet signed by the physician on August 16, 2008 that directed, "Lorazepam 1 mg tablet by mouth every 8 hours as needed for severe agitation." The August 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered seven (7) times in August 5,10,12,18,19, 27 and 28, as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following dates in August 3, 5,10,12,18,19, and 27, 2008.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SU COMPLET	
		095034	B. WIN	G		09/19/2008	
	OVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 425	There was no evide that the Lorazepam 2008 and that the Loadministered on the August 28, 2008. A face-to-face intending September 17, 2008 Employee #3. He/shand the Controlled I regarding the administered was reviewed 483.60(b), (d), (e) Pure facility must employee the facility must store allog the fa	nce on the August 2008 MAR was administered on August 3, orazepam was signed as e Controlled Drug Record for view was conducted on at approximately 3:55 PM with he acknowledged that the MAR Drug Record did not match histration of Lorazepam. The d on September 17, 2008. HARMACY SERVICES apploy or obtain the services of a t who establishes a system of hid disposition of all controlled letermines that drug records are account of all controlled drugs eriodically reconciled. Ils used in the facility must be ce with currently accepted les, and include the appropriate lonary instructions, and the		425			
		ovide separately locked, compartments for storage of		•			
					•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/19/2008	
	ROVIDER OR SUPPLIER	REHAB		REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
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F 431	controlled drugs listed Comprehensive Dru Act of 1976 and othe except when the fact drug distribution systematic stored is minimal and detected. This REQUIREMENT Based on observation determined that the store the medication manufacturer's specunits and medication JH2's room. The findings included 1. Facility staff failed accordance with the According to the fact Care Nursing Drug Maccording to the fact Care Nursing Drug Maccording, store unopened both degrees Fahrenheit opening, store for up 77 degrees F, Stopages 561-562 Xala stipulates, "Store int 36 degrees F to 46 of Control of the fact Care Nursing Drug Maccording to the fact Care Nursing Drug Maccording to the fact Care Nursing Drug Maccording to the fact Care Nursing Drug Maccording Store unopened both degrees Fahrenheit opening, store for up 77 degrees F, Stopages 561-562 Xala stipulates, "Store int 36 degrees F to 46 of Control of the fact Care Nursing Drug Maccording to the fact Care Nursing Drug	ed in Schedule II of the g Abuse Prevention and Control er drugs subject to abuse, sility uses single unit package stems in which the quantity id a missing dose can be readily. IT is not met as evidenced by: In and staff interview, it was facility staff failed to properly is in accordance to the sifications in two (2) of six (6) in improperly stored in Resident in manufacturer's specifications. If to store medications in manufacturer's specifications. It is in the manufacturer's specifications. If the store medications in manufacturer's specifications. If the store medication in manufacturer's specifications.	F 431	1.) 483.60(b), (d), (e) PHARM SERVICES 1. The Fortical Nasal Spray, 2 the Xalantan eye drops were and replacements were obtain Stored per manufacturers speed. Storage specifications on a medications will be adhered to 3. All licensed staff will be in sproper storage of medication. 4. Med pass audit will be done every six months, results subtour Nurse Manager and Director of review at quarterly Pharmacy meetings. 2.) 483.60(b), (d), (e) PHARM SERVICES 1. Employee # 24 was observed Med pass to ensure that meding not left in residents room unattended. 2. All licensed staff will be observed Med pass to ensure that meding not left in room unattended. 3. Staff will be in serviced on the pass protocol. 4. Med pass audit will be done every six months, results subtour Nurse Manager and Director of review at quarterly Pharmacy meetings.	ed on next cations were tended. ee on staff mitted to of Nursing for and QI ACY ed on next cations were tended. eerved during cations are the med. e on staff mitted to of Nursing for one of the med.	9/19/08 11/3/08 11/3/08 10/9/08 9/19/08 11/3/08 11/3/08 10/9/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION G	COMPLET	
		095034	B. WIN	G		09/1	9/2008
_	ROVIDER OR SUPPLIER	REHAB		7	REET ADDRESS, CITY, STATE, ZIP CODE 125 BUCHANAN ST., NE VASHINGTON, DC 20017	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 431	nasal spray and Xa in the medication can the medication can specific the medication of the container (1) Intact Xalantan (1) Intact Xalantan (2) Intact Xalantan (3) Intact Xalantan (4) Intact Xalantan (5) Intact Xalantan (6) Intact Xalantan (7) I	lantan eye drops were observed arts. cal nasal spray 200 units eye drops cal nasal spray 200 units eye drops view conducted at the time of the mployees #3 and edged that the Fortical nasal eye drops were stored medications at the resident's l. 2008 at approximately 10:00 AM on pass for Resident JH2, nedication at the resident's ut of the room from 10:05 AM M to the medication cart to lication to administer to the stations were left at the bedside: mg [1] tablet, Colace 100 mg [1] g [1] capsule, Vitamin C 500 mg zaprine 10 mg [1] tablet, Vitamin D 500mg/200mg [1] ate 325 mg tablet [1] tablet, 1] tablet, Multivitamin [1] tablet,	F	431	1. 483.65(a) INFECTION CONTR 1. The employees was immediately of the control and cleaning utensil simultane 3. In service was given to all staff resinfection control and proper food had. The Quality Assurance Coordinatinspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. will be given to the Administrator model. The mop immediately stored. 2. 483.65(a) INFECTION CONTR 1. The mop immediately stored. 2. The entire cook preparation areas inspected to ensure that cleaning utermoved. 3. An in service was given to staff resinfection control and proper food had a The Quality Assurance Coordinate inspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. will be given to the Administrator model. 3. 483.65(a) INFECTION CONTR 1. Employee was corrected immediant items. Will be given to the Administrator model. 3. 483.65(a) INFECTION CONTR 1. Employee was corrected immediant items. Will be given to the Administrator model in the Quality Assurance Coordinate inspect the kitchen every 10 days for compliance. All findings will be reviet the Department and a plan of correct be develop for noncompliant items. Will be given to the Administrator model in the proper for the Administrator model.	corrected. It to carry ously. It to carry ously. It garding andling. It weed with otions will This report onthly. OL Is were garding indling. It weed with otions will This report onthly. OL ately. Is were ensils were ensils were ensils were ensils were ensils were tonthly. OL ately. It weed with otions will This report or will or	9/14/08 9/27/08 10/25/08 9/27/08 10/25/08
	Handihaler [1] caps] tablet, Spiriva 18 mcg ule,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	•	095034	B. WING		09/19/2008	
•	ROVIDER OR SUPPLIER	k REHAB	7	REET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
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F 441 SS=D	A face-to-face intervof the observation wacknowledged that stored left unattended 483.65(a) INFECTION The facility must est control program destantary, and comformevent the develop disease and infection facility; decides what should be applied to maintains a record of actions related to infections related to infections at the floor motod, transferring for hands not washed a soiled nebulizer made on the floor, soiled liand oxygen concentrations and the floor, soiled liand oxygen concentrations and the floor, soiled liand oxygen concentrations are soiled nebulizer made on the floor, soiled liand oxygen concentrations are soiled nebulizer made on the floor, soiled liand oxygen concentrations are soiled nebulizer made on the floor, soiled liand oxygen concentrations.	view was conducted at the time with Employee #24. He/she the medications were improperly ed. ON CONTROL Itablish and maintain an infection signed to provide a safe, ortable environment and to oment and transmission of on. The facility must establish an ogram under which it ls, and prevents infections in the at procedures, such as isolation of an individual resident; and of incidents and corrective fections. IT is not met as evidenced by: ons, staff interview and record mined that facility staff failed to sevidenced by: in the main arrying food and floor mop at the op and sanitizer towels near od into pan without gloves, after returning to preparing food, chine, oxygen tubing observed iff strap for the mechanical lift, trator filer soiled; and failed to hnique while removing the soiled resident's room.	F 441	 4.) 483.65(a) INFECTION CONTE 1. Associates instructed to leave sain appropriate storage area. 2. This is monitored daily my super. 3. In services given to staff. 4 The Quality Assurance Coordinate inspect the kitchen every 10 days for 	nitized items 9/visors. or will or ewed with ctions will This report onthly. ROL d. tor will or ewed with ctions on od. tor will This report onthly. ROL cted. cions on od. n service or will or ewed with ctions will This report onthly. ROL cted. cions on od. n service or will or ewed with ctions will This report	19/08 10/11/08 10/25/08 9/19/08 10/11/08 10/25/08 9/14/08.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MUI		COMPLE	(X3) DATE SURVEY COMPLETED	
		095034	B. WING	;		09/19/2008	
	ROVIDER OR SUPPLIER	REHAB		72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE /ASHINGTON, DC 20017		
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F 441	The observations we kitchen on Septemb through 11:30 AM, in #13, who acknowled the observations. 1. At 8:40 AM, Employed laid to the employee laid to while placing meat of the employee where macaroni and across a food preparation of the employee #20 was from a cooking to see approximately 10:50. 6. Employee #21 was dishes with fruit. The removing one (1) gloffrom his/her ID holded did not wash hands returned to filling the	ere conducted in the main er 15, 2008 from 8:30 AM in the presence of Employee diged the findings at the time of oyee #20 was observed in the g two (2) hotel pans of cooked hand and a floor mop in other. The mop against the counter on same counter. Foor mop was observed leaning cook's preparation area where exared. Foyee #19 was observed carrying its the walk-in refrigerator ere food was being prepared. For ere sitting open on counter if spaghetti were located and ration area. For sobserved transferring rice erving vessel without gloves at AM. For sobserved filling dessert employee was observed ove, retrieved a sanitation card er, handed it to supervisor, and before replacing glove and e dessert dishes. For some statement of the main was a supervisor, and before replacing glove and endoser was observed in the supervisor, and before replacing glove and endoser dishes.	F 4	41	7. 483.65(a) INFECTION CONTROL 1. The nebulizer was cleaned. 2. All nebulizers were checked and cleaned as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 8. 483.65(a) INFECTION CONTROL 1. The tubing was removed. 2. All residents using oxygen tubing were inspected and tubing was removed as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 9.) 483.65(a) INFECTION CONTROL 1. Mechanical lift strap was sent immediately to laundry for cleaning. 2. All mechanical lift straps were assessed and cleaned as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting.	9/15/08 11/3/08 11/3/08 11/3/08 9/16/08 11/3/08 11/3/08 9/15/08 11/3/08 11/3/08	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095034	B. WIN	IG		09/1	9/2008
•	ROVIDER OR SUPPLIER	k REHAB		7:	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 441	acknowledged the findservations. The following observentions observations. The following observentions observations. 7. A nebulizer machinal observations. 7. A nebulizer machinal observations. 8. Oxygen tubing we oxygen concentratoring one (1) of one (1) on the floor. 9. The lift strap for the floor was observed soiled lift straps observed soiled lift straps observed of the floor was soiled with accurate of the floor was soiled with accurate of the floor oxygen concentration. 11. Facility staff failed while removing the stresident's room. On September 17, 2 Employee #24 perforing the el and right life. During the dressing	vations were made during the conducted on September 15 and sence of Employee #23 who indings at the time of the nine was observed with in room 314 in one (1) of one nes observed. vas observed connected to an or and on the floor in room 316, observation of oxygen tubing the mechanical lift on the 3rd soiled in one (1) of one (1)	F	441	10.) 483.65(a) INFECTION CONT 1. The filter was changed. 2 All residents on oxygen filters inspected and changed as needs 3. Staff will be in serviced on infecontrol practices. 4. Environmental rounds will be every shift, submitted to the Dire Nursing quarterly for presentation quarterly QI meeting. 11.) 483.65(a) INFECTION CONT 1. Disposal of infectious material was reviewed with employee # 2 2. Disposal of Infectious Material be adhered to during dressing changed as a staff will be in serviced on infection protocol. 4. Monthly random wound composite will be done by wound nurse, subdirector of Nursing for presentating quarterly QI meeting.	s were ed. ection done ector of in to FROL I policy 24. I Policy will hanges. ection etencies bmitted to	9/15/08 11/3/08 11/3/08 11/3/08 11/3/08 11/3/08

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ILTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
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_		095034	B. WING		09/1	9/2008
	ROVIDER OR SUPPLIER L MANOR NURSING &	k REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
F 441	Upon completion of #24 removed the cladressings) from the biohazardous recept A face-to-face intended in Employee #5 at app September 17, 2003 dressings should be the resident's room placed in the biohazutility Room. A review of the Infe Services) Policy with 1996 and last review the following statem "2. Disposal of Infe contaminated materitissue, dressing, pabefore being removing disposal. Such articipastic bag before removed in the such articipastic bag b	the dressing change, Employee ear bag (with the soiled trash can and placed it in the stacle in the Soiled Utility Room. View was conducted with proximately 11:00 AlM on B. He/she stated that the soiled eplaced in a red plastic bag in and the red bag should be cardous receptacle in the Soiled et an effective date of March 11, wed on July 31, 2008 revealed tents under Procedure: ectious Material - All infectious or itals to include, disposable per towels, etc, be bagged ed from the resident 's room for cles should be placed in 'red emoving such from the resident's of in appropriate receptacles." ewed on September 18, 2008.	F 4	41		
F 444 SS=D	The facility must red after each direct res	ENTING SPREAD OF quire staff to wash their hands ident contact for which cated by accepted professional	F4	44		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095034	B. WING	i		09/1	9/2008
	OVIDER OR SUPPLIER	REHAB		725	T ADDRESS, CITY, STATE, ZIP CODE BUCHANAN ST., NE ISHINGTON, DC 20017		
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F 444	Continued From pag	ge 72	F 44	44			
	Based on observation	T is not met as evidenced by: ons during a tour of the main er 15, 2008 from 8:40 AM was determined that facility		1 2 u	183.65(b)(3) PREVENTING SPR OF INFECTION I. The trash cans were replaced. 2. All trash cans were checked for a use in the kitchen.		9/14/08
		e trash receptacles for the hand		4 ir c th	3. An in-service is scheduled. 4 The Quality Assurance Coordinate nspect the kitchen every 10 days for the compliance. All findings will be revious the Department and a plan of correspondential titems.	or ewed with ections will	10/27/08.
	main kitchen. The d the used paper towe	ng sinks were observed in the esignated trash receptacles for all required lifting the lid before er towels, thus re-contaminating	•		vill be given to the Administrator m		10/25/08
		s made in the presence of acknowledged the findings at vation.					
F 454 SS=D	483.70 PHYSICAL E	NVIRONMENT	F 45	54			
	equipped, and maint	designed, constructed, ained to protect the health and personnel and the public.					
		T is not met as evidenced by:		1 2.	B. All doors checked. Staff was instructed not to prop oper.		
	September 15, 2008 AM, it was determine maintain safe fire safe open fire doors.	from 8:40 AM through 11:30 ed that facility staff failed to fety as evidenced by propping		w 4 in co th	with cans. The Quality Assurance Coordinate in the Augustian Assurance Coordinate in the Augustian August	or will or ewed with ctions will	
	The findings include:				vill be given to the Administrator mo		10/8/08
	that the door to the	e main kitchen, it was observed outside corridor by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	L MANOR NURSING	& REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017				
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F 454	cans. The door to	propped open with two (2) large he dry storage area was propped arge cans. Both doors were yee #13 as fire doors. These made in the presence of acknowledged the findings at	F	154			
F 514 SS=D	resident in accorda standards and practacurately docume systematically orga. The clinical record information to identify assessm services provided;	aintain clinical records on each nce with accepted professional citices that are complete; nted; readily accessible; and	F !	514			
	Based on record re (9) of 30 sampled re facility staff failed to Physician Order Sh consistently docum status and diet condiagnosis, consiste one (1) resident, copain medication and withholding blood pup on loose stool for transcribe a tube feresident,	view and staff interview for nine esidents, it was determined that or document allergies on the seet (POS) for one (1) resident, ent one (1) resident's code sistency, clarify one (1) resident's ntly describe reddened skin for ensistently document the use of dis effectiveness, explanation of the resure medication and follow for one (1) resident, accurately eding product order for one (1) dressing change was					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095034	B. WING		09/1	9/2008
	ROVIDER OR SUPPLIER	& REHAB	s	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 514	conducted for one document code statranscribe an order resident. Resident The findings included. The findings included and the resident of the Methad an allergy to Pin chart. The facility 21, 2008 indicated and ASA (Aspirin). Indicated the resident Physicians Order Staugust 5, 2008 indicated the resident Physicians Order Staugust 5, 2008 indicated the resident State Physicians Order Staugust 5, 2008 indicated the Physicians Order State Physicians Order Ph	(1) resident, consistently atus for one (1) resident and r for catheterization for one (1) ts #1, 2, 3, 4, 5, 8,10, 22 and 28. de: ed to document allergies on the heet (POS) for resident #1 dical revealed that Resident #1 renicillin (PCN) on the front sheet y admission assessment on June the resident was allergic to PCN. The history and physical ent was allergic to PCN. The Sheet (POS) Dated and signed licated that the resident has	F 51	1.) 483.75(I)(1) CLINICAL REC 1. All allergies were identified resident # 1. 2. All resident records will be rensure all allergies are identificare planned. 3. Staff will be in serviced on in documenting all allergies on plorder sheet. 4. Care plan audit on allergies by Nurse Manager or designed to Director of Nursing for presequarterly QI meeting. 2.) 483.75(I)(1) CLINICAL REC 1. The physicians who failed to me requirement will review the total president #2 and include the currer directive on the history. 2. The physicians will review all of resident's plans of care to insure compliance with this requirement. 3. The Medical Director will educar physicians on their responsibility total plan of care. Monthly audits conducted by facility staff to monit visit documentation for compliance reported will be prepared for Medi 4. The Medical Director will correct compliance as needed and submit report to the Administrator summareviewed, rates of compliance and actions taken or required.	on POS for reviewed to ed and mportance of hysician will be done e, submitted enting at ORDS eet this blan of care for nt advanced their te all attending to review the will be tor physician e monthly ical Director t physician it a quarterly arizing plans	11/3/08 11/3/08 11/3/08

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095034	B. WING _		09/1	9/2008	
	COVIDER OR SUPPLIER L MANOR NURSING 8	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE	
F 514	Exam form complete Advance Directives: The record lacked e document the currer Resident #2's H&P. A face-to-face interv September 16, 2008 He/she acknowledge Code" and that the current code status reviewed on Septem B. Facility staff failed current meal consist Guide and tray ticke A review of the Phys 1, 2008 through September 16, 2008 through September 16, 2008 reveal regular" A review of the "Safe July 21, 2008 reveal regular" A review of the September 16, 2 having lunch and cothe physicians order The "Safe Swallow Cothe The "Safe Swallow Cothe Physicians order The "Safe Swallow Cothe Phy	ed May 5, 2008 revealed, " DNR" vidence that the physician not code status when completing liew was conducted on at 2:40 PM with Employee #4. and that Resident #2 was a "Full physician did not document the conthe H&P. The record was aber 16, 2008. If to accurately document the ency on the "Safe Swallow to resident #2. Sician Order sheets for August attember 30, 2008 and signed by gust 12, 2008 directed, "Diet: Be Swallow Guide" last updated and " Meal consistencies: Foodember 16, 2008 lunch tray Regular [indicating the type of consuming a pureed meal as per soulder and the lunch tray ticket are that they were accurately consistencies.	F 514	4			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095034	B. WING_		09/19/2008	
	ROVIDER OR SUPPLIER	REHAB	S	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) 1D PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-		(X5) COMPLETION DATE
F 514	physicians order. A face-to-face intervine September 16, 2008 He/she acknowledgrand the lunch tray tip physician's order. The September 16, 2008 3. Facility staff failed Diabetes Mellitus list Transfer Form' for It is a "Inter-Agency Refundation of the signed and dated Juminimum Data Set (failed to reveal a diamediated to reveal a diamediated to reveal a diamediated to resident did not It is a mediated to record was review 4. Facility staff failed resolution of an area #4.	riew was conducted on B at 2:40 PM with Employee #4. ed that" A Safe Swallow Guide" cket did not reflect the current he record was reviewed on B. It to clarify a diagnosis of ted on the "Inter-Agency Referral	F 51	3.) 483.75(I)(1) CLINICAL RECO 1. Physician reviewed resident and determined that Resident a Diabetic. Finger sticks were because of steroids therapy in I 2 All other residents will be chensure diagnosis is correct. 3. All staff will be in serviced on "Inter-Agency Referral Transfer clarify all discrepancies. 4. Nurse Manager will conduct audits on diagnosis update and Director of Nursing for presenta quarterly QI meeting. 4.) 483.75(I)(1) CLINICAL RECO 1. Documentation was placed in #4 chart indicating resolution o area. 2. All other residents must be clarify documentation.	# 3 record # 3 was not being done hospital. ecked to review of Form" and monthly submit to ition at PRDS n Resident f reddened	11/3/08 11/3/08 11/3/08 9/16/08 11/3/08
	following nurses' not			3. In-service will be done on sta follow up documentation. 4. Weekly skin sheets will be coreviewed by wound nurse and sto Director of Nursing for preser quarterly QI meeting.	ompleted, submitted	11/3/08 11/3/08

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095034	B. WIN	G		09/19	9/2008
	ROVIDER OR SUPPLIER	REHAB	·	7.	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS-	. (X5) COMPLETION DATE
F 514	observed to right but applied" May 27, 2008 at 110 with a dry scab note" There was no further area. A face-to-face interved Employee #4 on Set He/she acknowledg area was not tracked of the area. 5. Facility staff failed assessment when Four Interved and the end when it was administed assessment when Four Interved Int	ttock and Proshield Plus was 20 (11:00 AM): "Reddened area dover the Right gluteus area or entry regarding the above skin rentry regarding the above skin return the state of the state	F	514	5A.) 483.75(I)(1) CLINICAL RECO 1. Resident # 5 was assessed an was no episode of loose stools. 2. Follow up documentation will be residents with change in condition 3. In-service will be done on staff importance of follow up documen 4. Nurse Manager or designee wi 24 hour report daily to ensure that changes are followed up.	nd there the done on the done on the done the done	11/3/08 11/3/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLET	
		095034	B. WING _		09/1	9/2008
	COVIDER OR SUPPLIER	& REHAB	S	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 514	had additional loose A face-to-face inter September 18, 200 #6. He/she acknow up documentation a to have loose stools September 18, 200 B. Facility staff faile assessment when F pressures. A review of the July physician's order th 100 mg tablet Losa mouth daily for hype blood pressure] less pressure] less than A review of the July administration recoi 23, 26, 27, and 29, blood pressure and in accordance with The IDT [interdiscip evidence that after reading was docum documented assess Resident #5's blood A face-to-face inter September 18, 200 #6. He/she acknow up documentation a	view was conducted on 8 at 11:30 AM with Employee viedged that there was no follow after the resident was observed at the record was reviewed on 8. In the revealed a at directed the following: Cozaar of the potassium one (1) tablet by the retension (hold if SBP [systolic is than 120 DBP [diastolic blood 60). In the record was withheld the physicians order. In the resident #5 had a low his/her medication was withheld the physicians order. In the resident was withheld the physicians order. In the resident's blood pressure ented as low, there were further sments or follow up regarding pressure. In the record was observed ressures. The record was	F 51	5B.) 483.75(I)(1) CLINICAL REC 1. Resident # 5 medications we adjusted. 2. Follow up documentation will on residents with change in con 3. In-service will be done on stathe importance of follow up ass and documentation. 4. Nurse Manager or designee 24 hour report daily to ensure the changes are reassessed and for documentation is done.	re be done dition. If regarding essment will review hat all acute	11/3/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		095034	B. WING		09/1	9/2008
	ROVIDER OR SUPPLIER	<u> </u>	;	STREET ADDRESS, CITY, STATE, ZIP COD 725 BUCHANAN ST., NE WASHINGTON, DC 20017	•	5 /2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 514	C. Facility staff faile pain level and effect when administered A review of the Maradministration record w/APAP 5/500 Capadministered on Matylox Oxycodone with word with the word of the "Vita March 13, 14, 17, 13, 2008 pain level (#5.) According to the "A Report, Resident #5 assessed on March 19, 30 and 31, 2008 The record lacked emedications were at the resident's pain leassessment was not determine if the pair effective. A face-to-face intervised in the second sistently document of the record was reviewed.	ed to consistently document the ctiveness of pain medication for Resident #5. Inch 2008 MAR [medication rd] revealed that Oxycodone one for minor pain was earch 14, 28, 29, and 31, 2008. Inch 2008 MAR [medication rd] revealed that Oxycodone one for minor pain was earch 14, 28, 29, and 31, 2008. Inch 2008 MAR [medication revealed that on an March 12, 13, 14,16, 17, 31, 2008. Inch 2008 MAR [medication revealed that on an March 12, 13, 2008. Inch 2008 MAR [medication revealed that on an March 12, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2	F 5	5C.) 483.75(I)(1) CLINICAI 1. Resident # 5 was assess and medicated as needed assessment and documer 2. All licensed staff will be med pass to ensure considocumentation of adminismedication. 3. Staff will be in serviced protocol for as needed med. Med pass audit will be every six months, results and Nurse Manager and Direct review at quarterly pharmatering.	ssed for pain I with follow up ntation. cobserved during istent tered as needed on med pass edications. done on staff submitted to ctor of Nursing for	9/18/08 11/3/08 11/3/08 11/3/08

NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB SUMMANY STATEMENT OF DEFICIENCES TREET ADDRESS, CITY, STATE, 20°CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017 SUMMANY STATEMENT OF DEFICIENCES WASHINGTON, DC 20017 PREFIX FACH DEFICIENCY VAUT TE PRECEDED BY PULL REGULATORY OF 150 DENTIFYING INCOMMITCH) F 514 Continued From page 80 dressing change was conducted for Resident #8. A review of the IDT progress notes revealed, September 14, 2008 due to resident receiving his/her shower dressing change every 3 days. Right toe area dressing change as ordered" On September 16, 2008 a dressing change to the right ankle and the right toe was observed. The old dressing (that was removed) was dated September 14, 2008. Upon completion of the dressing change to the aforementioned areas, Employee #15 failed to sign the MAR [indicating that the dressing change was conducted to the right ankle and the right toe was observed. The old dressing (that was removed) was dated September 14, 2008. A review of the September 2008 MAR revealed that on September 9, 12, and 15, 2008 a dressing change was conducted to the right ankle and the right sake and with the MAR [indicating that the dressing change was conducted on September 16, 2008 at 355 PM with Employee #6. He/she acknowledged that MAR was not signed indicating that the dressing change was conducted as per the physicians order. The record was reviewed on September 16, 2008. 7. Facility staff failed to document the correct concentration of a tube feeding product for Resident #10 on the Physician's Order Sheet (POS). A physician's telephone order dated July 17, 2008		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
STREET ADDRESS, CITY, STATE, ZIP CODE 728 BUCHANNATS, NE MASHINGTON, DC 20017			095034	B. WIN	G		09/19	9/2008
F514 Continued From page 80 dressing change was conducted for Resident #8. A review of the IDT progress notes revealed, September 15, 2008 Nursing note at 1455, "Right ankle and the right tankle and the right towas observed. The old dressing change are sometiment of the spetember 14, 2008. Upon completion of the dressing change to the aforementioned areas, Employee #15 failed to sign the MAR (indicating that the dressing change was conducted to the right and was conducted to the right and the right to the ARR was signed on September 14 and 16, 2008 after the dressing change was completed. A review of the September 2008 MAR revealed that on September 9, 12, and 15, 2008 aftersting change was completed. A face-to-face interview was conducted on September 14 and 16, 2008 after the dressing change was conducted on September 16, 2008 at 3:55 PM with Employee #6, He/she acknowledged that MAR was not signed indicating that the dressing change was conducted as per the physicians order. The record was reviewed on September 16, 2008. 7. Facility staff failed to document the correct concentration of a tube feeding product for Resident #10 on the Physician's Order Sheet (POS).			REHAB	•	72	25 BUCHANAN ST., NE		
dressing change was conducted for Resident #8. A review of the IDT progress notes revealed, September 15, 2008 Nursing note at 1455, "Right ankle dressing changed yesterday September 14, 2008 due to resident receiving his/her shower dressing change every 3 days. Right toe area dressing change every 3 days. Right toe area dressing change as ordered" On September 16, 2008 a dressing change to the right ankle and the right to was observed. The old dressing [that was removed] was dated September 14, 2008. Upon completion of the dressing change to the aforementioned areas, Employee #15 failed to sign the MAR [indicating that the dressing change was completed]. A review of the September 2008 MAR revealed that on September 9, 12, and 15, 2008 a dressing change was conducted to the right ankle and the right 5th toe. The record lacked evidence that the MAR was signed on September 14 and 16, 2008 after the dressing change was conducted on September 16, 2008 at 3:55 PM with Employee #6. He/she acknowledged that MAR was not signed indicating that the dressing change was conducted as per the physicians order. The record was reviewed on September 16, 2008. 7. Facility staff failed to document the correct concentration of a tube feeding product for Resident #10 on the Physician's Order Sheet (POS).	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	(X5) COMPLETION DATE
	F 514	A review of the IDT September 15, 2008 ankle dressing change and 2008 due to resident dressing change dressing change ever dressing changed at the state of the s	progress notes revealed, Nursing note at 1455, "Right ged yesterday September 14, t receiving his/her shower ery 3 days. Right toe area s ordered" 2008 a dressing change to the ight toe was observed. The old emoved] was dated September the dressing change to the as, Employee #15 failed to sign that the dressing change was tember 2008 MAR revealed that and 15, 2008 a dressing ted to the right ankle and the cord lacked evidence that the September 14 and 16, 2008 hange was conducted on at 3:55 PM with Employee #6 ed that MAR was not signed ressing change was conducted s order. The record was aber 16, 2008. It to document the correct abe feeding product for Resident n's Order Sheet (POS).	F	514	 Next treatment done on reside was signed on MAR. All licensed staff will be obsert treatment competencies to ensu documentation of treatment done Staff will be in serviced on wo competency protocol. Monthly treatment competency randomly done by wound care in submitted to Director of Nursing 	ent # 8 ved during re e. und ies will be urse and for	11/3/08 11/3/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILD	DING			
		095034	B. WING	·—		09/19	9/2008
	OVIDER OR SUPPLIER L MANOR NURSING 8	REHAB	,	72	EET ADDRESS, CITY, STATE, ZIP CODE 25 BUCHANAN ST., NE (ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 514	"Osmolite 1.2 via G- A review of Resider	ge 81 hysician the same day, directed, tube every 4 hours" ht #10's record revealed a POS 008,"Osmolite 1 can every 4	F 5	14	7.) 483.75(I)(1) CLINICAL RECO 1. Physician order sheet for residuals reviewed, and reflects curre feeding orders. 2. All residents with tube feeding receive the specified formula.	dent # 10 ent tube	9/16/08
	hours from 0600 - 2 According to the ma produced as follows				 Staff will be in serviced on implementing the specified formula feeding ordered by physician. Nurse Manager or designee value feeding orders monthly. 	ıla of tube	11/3/08
	Employee #4 on Se He/she acknowledg Osmolite was not do	priew was conducted with ptember 16, 2008 at 10:00 AM. ed that the correct strength of ocumented on the August 12, ord was reviewed September					
	status on the History Resident #22. A review of the Adm Exam form complete Advance Directive A review of the Do N Resuscitation/Advar January 25, 2008 re A review of review of September 1, 2008 signed by the physic revealed, " Advance The record lacked examples of the signed by the physic revealed of the signed by the signed by the physic revealed of the signed by the physic revealed of the signed by the physic revealed of the signed by	Not Attempt noce Directive, last updated ovealed, "DNR" of the physician order form for through October 31, 2008 and cian on August 29, 2008 ce Directives: DNR" vidence that the physician rent code status when			8.) 483.75(I)(1) CLINICAL RECO 1. The physicians who failed to meet requirement will review the total plantesident #22 and include the current directive on the history. 2. The physicians will review all of the resident's plans of correction to insucompliance with this requirement. 3. The Medical Director will educate physicians on their responsibility to total Plan of Care. Monthly audits we conducted by facility staff to monitor visit documentation for compliance, reports will be prepared for Medical 4. The Medical Director will correct prompliance as needed and submit a report to the Administrator summarize reviewed, rates of compliance and cations taken or required.	this n of care for t advanced eir all attending review the rill be physician Monthly Director hysician quarterly zing plans	11/3/08 11/3/08 11/3/08

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻¹ A. BUILD!	TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		095034	B. WING _	· · · · · · · · · · · · · · · · · · ·	09/1	9/2008
	ROVIDER OR SUPPLIER	& REHAB	s	TREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	OULD BE CROSS-	(X5) COMPLETION DATE
	A face-to-face inter September 19, 200 He/she acknowledge the current code ston September 19, 2 9. Facility staff faile for In/out catheteriz #28. A review of the med physician order date catheterization PRI A review of the Phy signed August 5, 20 order dated July 21 catheterization PRI inability to void." A review of the inter 2008 until present I resident received a sleep]. Facility staff	rview was conducted on 28 at 9:50 AM with Employee #5. Iged that H&P did not document tatus. The record was reviewed 2008. ed to correctly transcribe an order zation for Resident edical record reveals an interim ted July 24, 2008 for "intermittent N and daily every hs" ysicians Order Sheet dated and 2008 indicated an "as needed" 1, 2008 "Intermittent N at Hs daily for sensation of erdisciplinary notes from July 21, lacked documentation that the an In/out cath every HS [hour of ff was unable to provide nput and Output records for this	F 51		ECORDS ttent y every HS iscontinued for transcribed as in importance of s correctly nee will review	9/18/08
	Employee #4 at apple September 17, 200 the order for interm	rview was conducted with proximately 4:00 PM on 08. He/she acknowledged that nittent catheterization was not ed. The record was reviewed 08.				

CENTERS	FOR MEDICARE & MEDICAID SERVICES			A FORM					
	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM ID NFs	PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 9/19/2008					
	OVIDER OR SUPPLIER MANOR NURSING & REHAB	STREET ADDRESS, CITY, S 725 BUCHANAN ST., WASHINGTON, DC	· ·						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	ENCIES							
F 274	483.20(b)(2)(ii) RESIDENT ASSESSI	MENT- WHEN REQUIR	.ED						
	or should have determined, that there he condition. (For purpose of this section resident's status that will not normally standard disease-related clinical interventions.)	ive assessment of a resident within 14 days after the facility determines, has been a significant change in the resident's physical or mental in, a significant change means a major decline or improvement in the resolve itself without further intervention by staff or by implementing rentions, that has an impact on more than one area of the resident's inary review or revision of the care plan, or both.)							
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to clearly document the reasons the Interdisciplinary team did not complete a significant change Minimum Data Set (MDS) for Resident #3 after he/she returned from a hospitalization.								
	The findings include:								
	A review of an annual MDS completed April 24, 2008 coded Resident #3 as follows: Section G - Physical Functioning and Structural Problems - all Activities of Daily Living (ADL) coded the resident as being independent, with extensive assistance required for bathing.								
	Section H - Continence in the last 14 da function.	ays - The resident was co	ded as continent for bowel and blad	der					
	Section M - Skin Condition - The resid	Section M - Skin Condition - The resident's skin was intact.							
	The resident was hospitalized from July July 24, 2008, with an Assessment Reference			pleted on					
	Section G - The resident was coded as	requiring extensive assist	ance for toileting, dressing and bath	ing.					
	Section H - The resident was coded as	being occasionally incont	inent.						
	Section K - Oral/Nutritional Status - Th	ne resident was coded for	weight loss.	·					
	Section M - The resident was coded as having three (3) Stage I pressure sores, abrasion/bruises, turning and repositioning program and ulcer care.								
	Section P - Special Treatments and Promedical condition.	cedures - The resident wa	is coded for requiring monitoring ar	n acute					
•	According to the "MDS 2.0 User's Man	nual", page 2-7,	-						
	The state of the s								

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

The above isolated deficiencies pose no actual harm to the residents

CARROLL MANOR NURSING & REHAB MASHINGTON, DC	STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs NAME OF PROVIDER OR SUPPLIER		A. BUILDING COMPLETE: 9/19/2008 STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE			
PREPEX TAGE SUMMARY STATEMENT OF DEFICIENCIES F 274 Continued From Page 1 "A Significant Change in Status (SCSA) assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks." According to the "Weekly Skin Sheet" dated July 15, 2008, the resident's pressure sores were healed. According to the occupational therapist's note dated July 22, 2008, "Patient's ADL status returned to prior status and Patient was therefore discharged from Occupational Therapy on July 16, 2008." There was no evidence in the record that the Interdisciplinary team (IDT) discussed the expectation that the resident's change in condition would resolve within a short period of time. A face-to-face interview was conducted with Employee # 2 at approximately 5:30 PM on September 19, 2008. He/she acknowledged that there was no documentation from the IDT that discussed the resident's change of condition and the expected resolution of those changes within a short period of time. The record was reviewed on September 16, 2008.	RROLL	MANOR NURSING & REHAB	1			
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