STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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.	F 000		
F 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to provide surety bond coverage to assure the security of all funds in the residents' account. The findings include: 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	F 161	**483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY** 1.The Surety Bond for the Resident Trust Fund was increased from $275,000 to $375,000. 2.All residents with a Trust Fund account will be protected by the increase of the amount of the Surety Bond. 3.On a monthly basis, the Trust Fund bank statements will be reviewed for the daily balance and not the beginning and ending balances to ensure the Surety Bond is in excess of the amount in the bank. The Trust Fund bank statements will be 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 monthly thereafter. 4. A quarterly report summarizing compliance And corrective action, if needed, will be Prepared for the Quarterly QI Committee.	9/17/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eileen Mullaney, NHA	Administrator	10-16-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 161	Continued From page 1 happened because it was a weekend". A subsequent interview was held on September 17, 2008 at 9:15 AM and Employee #9 stated that he/she understood the regulation and the surety bond would be increased.	F 161		
F 164 SS=D	483.10(e), 483.75(l) (4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e) (3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	**483.10(e), 483.75(l) (4) PRIVACY AND CONFIDENTIALITY** 1. Resident's privacy was maintained for all future dressing changes for Resident # 8. 2. Dressing change policy was reviewed with all staff to ensure that privacy will be maintained during dressing change. 3. Wound care nurse will conduct monthly random competencies on licensed staff. 4. Results will be submitted to Director of Nursing for presentation to quarterly QI Committee for review.	9/17/08 10/3/08 10/2/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 Based on observations for one (1) of six (6) dressing changes, it was determined that facility staff failed to provide privacy during a dressing change for Resident #8. The findings include: On September 14, 2008 at 11:32 AM, Employee #15 was observed administering a dressing change to Resident #8's right ankle and right 5th toe. Employee #15 failed to close the resident's door and pull the privacy curtain prior to the dressing change. Resident #8 resides in a semiprivate room. During the dressing change, Employee #5 entered the room to assist the nurse with the dressing change and the door and privacy curtain remained open.	F 164	**483.10(g) (1) EXAMINATION OF SURVEY RESULTS** 1. The Survey notebook was located in a rack at the front desk. It was placed on the ledge in front of the Front Desk Receptionist when brought to the employee's attention. 2. The employee checked the residents rights boards on each unit and found the survey results notice posted in units 1, 2, 3, 4, 5 & 6. 3. The front desk Receptionist will document the presence of the survey notebook in the Receptionist log book on each shift. 4. The Communication Manager will monitor the documentation and prepare a monthly report for the Administrator, as well as a quarterly report for the facility Quality Improvement Committee.	9/18/08 9/18/08 10/1/08 11/3/08
F 167 SS=C	483.10(g) (1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to make the survey results available for examination and	F 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 3 readily accessible to residents and to post a notice of their availability. The findings include: Observations made by the survey team from September 15-18, 2008 of the lobby area and three (3) resident units, failed to reveal the location of survey results or notices identifying where survey results could be located. On September 18, 2008 at approximately 7:30 PM a face-to-face interview was held with Employee #1 who acknowledged that the survey results were not posted in the identified location. He/she stated that signage would be posted indicating the location of survey results on each unit.	F 167		
F 225 SS=D	483.13(c) (1) (ii)-(iii), (c) (2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	**483.13(c) (1) (ii)-(iii), (c) (2) - (4) STAFF TREATMENT OF RESIDENTS** 1. Resident # 4- Bruised area to upper back has resolved. Currently resident # 4 has no bruises. 2. All residents will be assessed for skin discoloration and for those identified, an investigative reports will be done and submitted to the Department of Health. 3. Unit management to monitor daily new incidence of skin discoloration, initiate an investigation and report to wound care nurse for tracking. 4. Results will be submitted to the Director of Nursing for presentation in the quarterly QI Committee Meeting.	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	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to document an investigation for Resident #4 who had bruises of unknown origin. The findings include: A review of Resident #4's record revealed the following nurses' notes: August 11, 2008 at 2055 (8:55 PM): "Charge nurse reported purplish discoloration on resident's right upper back region. No hematoma observed. No signs or symptoms of pain..." A face-to-face interview was conducted on September 19, 2008 at 10:30 AM with Employee #3. He/she stated, "We looked at the way (Resident #4) walks thinking maybe [he/she] was	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 bumping into walls. We looked at the chairs [he/she] sat in all over the unit. We couldn't determine where the bruises came from. I walked with (Resident #4) to [his/her] bathroom and saw that the metal arm was pulled down. It hit the resident right in the same spot that the bruise was. We think that may have been what caused the bruise. I am going to ask Physical Therapy to pad that bar." There was no evidence that the investigation into the cause of Resident #4's bruises was completed. Employee #3 acknowledged that he/she failed to complete the investigation. The record was reviewed September 19, 2008.	F 225		
F 226	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and staff interview, it was determined that facility staff failed to implement a policy that affords protection to all residents during alleged abuse investigations. The findings include: A review of the facility's Policy No.: 2003.1 "Abuse & Neglect Investigation" revealed, "Employees who have been accused of resident abuse may be reassigned to nonresident duties or suspended from duty, until the Administrator reviews the results of the investigation."	F 226	**483.13(c) STAFF TREATMENT OF RESIDENTS** 1. No specific resident identified 2. Currently there are no alleged abuse allegations against any staff member. 3. The practice has been to suspend a staff member who has been accused of any resident abuse until the allegation has either been substantiated or unsubstantiated. The policy will be amended to read "Employees who have been accused of resident abuse will be suspended from duty, until the Administrator reviews the results of the Investigation. 4. The Social Services Manager will monitor for departmental compliance and will report immediately any discrepancies to the Administrator and appropriate Department Director.	10/28/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 A face-to-face interview held on September 19, 2008 at 12:01 PM with Employee #10. He/she stated, "In the four (4) years I have been here, staffs were usually re-assigned to other units." Employee #1 acknowledged that staff were re-assigned to other care areas [within the facility] during an alleged abuse investigation in a face-to-face interview conducted on September 19, 2008 at 5:00 PM. The Abuse & Neglect Investigation policy lacks evidence that it provides protection to all residents during the investigation of alleged abuse.	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during the medication pass, for one (1) of eight (8) residents, it was determined that the facility staff failed to knock on Resident JH4's door before entering the room. The findings include: On September 15, 2008 at approximately 10:30 AM during the morning medication pass, Employee #25 entered the room of Resident JH4 without knocking on the door.	F 241	**483.15(a) DIGNITY** 1. Resident JH4's dignity was addressed with staff and staff will knock prior to entering the room. 2. Staff was inserviced on residents dignity and will knock on all residents doors prior to entering. 3. Unit management will monitor staff on on unit for compliance. 4. Any incidence of non-compliance will be reported to Director of Nursing to report to quarterly QI Committee for review.	9/15/08 11/3/08 10/8/08 10/9/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 7 A face-to-face interview was conducted on September 15, 2008 at approximately 3:30 PM with Employee #25. Employee #25 acknowledged that he/she did not knock on the resident's door prior to entering the room.	F 241		
F 253 SS=E	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview during the environmental tour conducted on September 15, 2008 from 8:45 AM through 9:00 PM and September 16, 2008 conducted from 8:45 AM through 1:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, and homelike environment for residents as evidenced by: soiled/damaged floors, wall paper borders, doors, walls, baseboards, exhaust vents, accordion bathroom doors, furniture, HVAC (Heating, Ventilation and Air Conditioning) units, ceiling tiles, blinds, window screens, thresholds to bathroom doors, call bells, counter tops, sprinkler heads and linen carts; caulking damaged on backsplash in bathrooms; dusty bed frames, top of closet surfaces, bathroom lamps, shelf over the bed, window sills, and damaged/soiled toilet seats. These observations were made in the presence of Employees # 3, 4, 5, 6, 7, 8, 23, 26 and 27. The findings include:	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED/
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 8 1.13 of 64 floors were observed damaged/soiled as follows: 1st floor rooms: 125, 131, 136 and 156. 2nd floor rooms: 207, Activity room. 3rd floor rooms: 342, staff bathroom and Rehabilitation toilet room. 4th floor rooms: 405, 424 and 426. 5 East room: 562. 2.12 of 64 wall paper borders were observed damaged/marred as follows: 1st floor rooms: 103, 107, 136, 153 and 156. 2nd floor room: 231. 3rd floor rooms: 347 and 354. 4th floor rooms: 405 and 454. 5th floor rooms: 502 and 530. 3. 32 of 64 doors were observed marred/worn/soiled as follows: 1st floor rooms: 103, 107, 115, 124, 130, 131, 141, 153 and 156. 2nd floor rooms: 207, 228, 231, 245, 253, 254 and storage and soiled utility rooms. 3rd floor rooms: 301, 326, 347 and pantry. 4th floor rooms: 405, 424, 426, 454, storage and soiled utility rooms. 5th floor rooms: 502, 510, 515, 546 and Dining room. 5 East room: 560. 4. 28 of 64 rooms were observed with marred/scarred/damaged walls as follows: 1st floor rooms: 107, 115, 124, 126, 136, clean utility room, bathing room and rest room. 2nd floor rooms: 202, 207, 213, 228, 231, 253, storage room, and activity room. 3rd floor rooms: 314, 354, and pantry. 4th floor rooms: 405, 410, 416, 426, clean utility	F 253	**1.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. An outside contractor was notified to repair and/or replace floors. 2. All other floors were inspected and identified. repairs and replacement will be done by an outside contractor. 3. Monitor the floors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **2.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The wallpaper borders have been ordered and will be replaced upon receipt of the new borders. 2. All other wall paper borders were Inspected and will be replaced as needed. 3. Monitor the wallpaper borders and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **3.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The doors were cleaned and restained. 2. All doors were inspected and will be restained as needed. 3. Monitor the doors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly.	10/16/08 10/17/08 On-going 11/3/08 11/3/08 On-going 10/6/08 10/6/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 9 room and day room. 5th floor rooms: 505, 546 and 530. 5 East room: Clean utility room. 5. 20 of 64 rooms were observed with soiled/damaged cove base as follows: 1st floor rooms: 107, 126, 131, 141, 153, 156, soiled utility room and pantry. 2nd floor room: 207. 3rd floor rooms: 324, 326, 342, 354 and Rehabilitation room. 4th floor rooms: 405, 454 and bathing room. 5th floor rooms: 523, 530, and staff bathroom. 6. 12 of 64 exhaust vents were observed soiled as follows: 1st floor rooms: 112, 131, 153, laundry, bathing room, and soiled utility. 2nd floor rooms: 202 and 241. 3rd floor room: 301. 4th floor rooms 405 and 454. 5th floor: staff bathroom. 7. 14 of 64 accordion bathroom doors were observed damaged/soiled as follows: 1st floor rooms: 112, 136, 153 and 156. 2nd floor rooms: 245 and 253. 3rd floor rooms: 301, 316, 326 and 354. 4th floor rooms: 416 and 454 5th floor rooms: 523 and 530. 8. 14 of 64 rooms were observed with worn/marred furniture as follows: 1st floor rooms: 107, 112, 130, and day room. 2nd floor rooms: 228, 241, and day room. 4th floor rooms: 405, 410, 416, and 445. 5th floor room: 546. 5 East room: 560 and a geri chair stored in tub room.	F 253	**4.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The walls are scheduled to be repaired. 2. All walls were inspected on 10/17/08 and Will be repaired as needed. 3. Monitor the walls and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **5.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The soil and damaged cove bases will be cleaned and repaired. 2.. All other cove bases were inspected on 10/5/08, cleaned and will be repaired as needed. 3. Monitor the cove bases and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **6.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Vents in rooms identified on #6 have been cleaned and power washed. 2. Inspect remaining rooms and repair and clean as needed. 3.. Monitor the vents in the rooms and take corrective action as needed. 4.. Report monitoring results and corrective actions to the QI committee quarterly. **7.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Rooms identified in #7 have been repaired and cleaned. 2..Inspect remaining rooms and repair and clean as needed. 3. Monitor the accordion bathroom doors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly.	11/3/08 11/3/08 On-going 11/3/08 11/3/08 On-going 11/03/08 On-going 11/03/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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: 301,316, 326, 335 and 342. 4th 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: Soiled linen, soiled utility and hallway by 245. 3rd floor rooms: 335 and Rehabilitation room. 4th floor rooms: 426, clean utility room, bathing room and activity room. 5th 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 room: 136. 2nd floor rooms: 228, 245, activity room, end of hall by 254 and beauty shop. 3rd floor rooms: 301, 314, 347 and 354. 4th floor room: 405. 5th floor room: 510. 12. Two (2) of 64 rooms were observed with damaged window screens as follows: rooms 314 and 502. 13. Four (4) of 64 thresholds were observed damaged as follows: 1st floor rooms: 112 and 131.	F 253	**8.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The furniture will be repaired in its entirety. 11/3/08 2. All other furniture were inspected and will be repaired as needed. 11/3/08 3. Monitor the furniture and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **9.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The HVAC units were cleaned and repaired. 9/17/08 2. All other HVAC units were inspected, cleaned and repaired as needed. 9/22/08 3. Monitor the HVAC units and take corrective action when needed. 11/3/08 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **10.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The soiled/damaged ceiling tiles were replaced. 10/10/08 2. All other ceiling tiles were inspected and replaced, as needed. 10/13/08 3. Monitor the ceiling tiles and take corrective action when needed. 11/3/08 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 11 2nd floor room: 253. 5th floor room: 532 14. Three (3) of 64 rooms were observed with functional but damaged call bells as follows: 124, 130 and 153. 15. One (1) of one (1)) worktable in hallway on 1st floor damaged laminate by room 112. One (1) of one (1) counter top in 4th floor activity room. 16. Nine (9) of 14 sprinkler heads observed with accumulated debris as follows: 1st floor rooms: one (1) of two (2) in pantry and three (3) of three (3) in dining room, 3rd floor room: Two (2) of four (4) in the Rehabilitation room. 5th floor room: Two (2) of four (4) in the activity room. 5 East room: One (1) of one (1) in 562. 17. Five (5) of 10 yellow linen transport carts were observed soiled on the interior and exterior surfaces in the 2nd floor, 3rd floor and 4th floor laundry rooms. 18. 13 of 64 rooms observed with back splash area above sink with damaged caulking in the following areas: 1st floor rooms: 131 and rest room. 2nd floor rooms: 228, 245, 253, bathing room and employee rest room. 3rd floor room: Employee rest room. 4th floor room: 445. 5th floor rooms: 510, 530, soiled utility room and toilet in activity room. 19. 14 of 64 rooms were observed with dusty bed	F 253	**11.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Removed blinds in windows identified in #11. 2. Inspect remaining window blinds and clean as needed. 3. Monitor condition of blinds and take correction actions when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **12.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1 The window screens were replaced. 2. All window screens were inspected and Replaced as needed. 3. Monitor the window screens and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **13.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. An outside contractor was notified to replace all thresholds.. 2. All other thresholds were inspected and will be replaced as needed. 3. Monitor the condition of the threshold and take correction actions when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **14.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The call bells were repaired. 2. All other call bells were inspected on 9/16 and repaired. 3. Monitor the condition of the call bells and take correction actions needed. 4. Report monitoring results and corrective actions to the QA committee quarterly.	9/23/08 9/23/08 On-going 11/3/08 11/3/083. On-going 9/17/08 9/17/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 12 frames as follows: 1st floor rooms: 107, 124, 126, 136 and 156. 2nd floor rooms: 228 and 245. 3rd floor room: 342. 4th floor rooms: 405, 424 and 426. 5th floor room: 510. 5 East rooms: 560 and 564. 20. Seven (7) of 64 rooms were observed with the top surface of the closet dusty as follows: 1st floor rooms: 107, 130 and 153. 2nd floor rooms: 213, 228 and 254. 4th floor room: 405. 21. Seven (7) of 64 rooms were observed with dusty lights in the bathroom as follows: 1st floor rooms: 126 and bathing room. 2nd floor rooms: 202, 228 and 254. 3rd floor room: Bathing room. 4th floor room: 454. These findings were acknowledged by the above cited employees at the time of the observations.	F 253	**15.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The laminate material was ordered to replace the worktable. 10/13/08 2. All other worktables were inspected and will be repaired as needed. 11/3/08 3. Monitor the worktables and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **16.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The sprinkler heads were cleaned of debris. 10/13/08 2. All sprinkler heads were inspected and Cleaned as needed. 10/13/08 3. Monitor the sprinkler heads and take corrective action when needed. 11/3/08 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **17.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. The carts were cleaned and sanitized. 9/19/08 2. The Personal Laundry Aide was inserviced on proper cleaning & sanitizing. 9/19/08 3. Monitor the carts and take corrective action when needed. 11/308 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **18.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Back splash was ordered and will be repaired/replaced upon arrival of materials. 11/3/08 2. All back splash was inspected On 10/16 and will be repaired/replaced accordingly. 11/3/08 3. Monitor the back splash and take corrective action when needed. 11/308 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 13 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. 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 accurately code the Minimum Data Set (MDS) assessment for Resident #4. The findings include: A review of Resident #4's record revealed an initial physician's order dated May 1, 2008 and renewed June 19, 2008 and August 14, 2008, directing, "Monitor weights x 4 weeks; resident is on weight reduction diet." The quarterly MDS assessments completed June 10 and September 9, 2008 failed to code the resident in Section K as "On a planned weight change program." A face-to-face interview with Employee #3 was conducted on September 19, 2008 at 10:30 AM. He/she acknowledged that the MDS assessments	F 278	**19.) 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Dusty bed frames identified in #19 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of bed frames and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly. **20. 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Rooms identified with dusty closets (top) in #20 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of closets and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly. **21. 483.15(h) (2) HOUSEKEEPING MAINTENANCE** 1. Rooms identified with dusty lights in #20 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of lights and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly.	11/03/08 11/03/08 11/03/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 14 were inaccurately coded. The record was reviewed September 19, 2008.	F 278	**483.20(g) - (j) RESIDENT ASSESSMENT** 1. Resident # 4 was reviewed by the floor dietitian. The dietitian spoke with MDS team and the change was coded on the Section K as Planned WT change program. 2. The dietitians will review charts that have physician orders for planned weight change program and then make the necessary changes to Section K. 3. An in-service on the importance and accuracy of completing Section K will be given by the Clinical Nutrition Manager. The Clinical Manager will Randomly audit charts monthly and review findings with floor dietitians and MDS Nurses. 4. The Clinical Nutrition Manager will Report monthly audit results and corrective Interventions, if needed, in a quarterly Report to the QI Committee.	11/3/2008
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to develop care plans with appropriate goals and approaches for two (2) residents for potential adverse interaction for the use of nine (9) or more medications and one (1) resident for Allergies. Residents # 1 and 15 The findings include:	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 15 1. Facility staff failed to develop a care plan for the potential adverse interaction for the use of nine (9) or more medications and allergies for Resident #1. A review of the clinical record for Resident #1 revealed physician's orders dated and signed August 5, 2008 that include the following medications: Clopidogrel Bisulfate (Plavix), Potassium Chloride (K-Dur), Sertraline HCL (Zoloft), Zolpiderm Tatrate (Ambein), Olanzapine (Zyprexa), Tylox, Albuterol, Advair Diskus, Calcium Carbonate/Vitamin D3, Diltiazem HCL (Cardizem CD) and Docusate Sodium (Colace). A review of the medical record revealed that Resident #1 had an allergy to Penicillin (PCN) on the front sheet in chart. The facility admission assessment on June 21, 2008 indicated the resident was allergic to PCN and ASA (Aspirin). The history and physical indicated the resident was allergic to PCN. A review of care plans last updated on August 21, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications or allergies. A face-to-face interview was conducted with Employee #5 at approximately 4:00 PM on September 18, 2008. He/she acknowledged that the record lacked care plans for the potential adverse drug interaction for the use of nine (9) or more medications and allergies. The record was reviewed September 18, 2008. 2. Facility staff failed to develop a care plan for	F 279	**1.) 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS** 1. Resident #1Careplan was updated to reflect 9 or more meds and allergies. 2. All residents with 9 or more meds and allergies will be care planned. 3. Staff will be educated on the importance of care planning 9 or more meds and allergies. 4. Care plan audits will be done monthly by the Nurse Manager or designee and submitted to Director of Nursing to be presented at quarterly QI meeting **2.) 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS** 1.Resident # 15 Careplan was updated to reflect 9 or more meds usage. 2. All residents with 9 or more meds will be care planned. 3. Staff will be educated on the importance of care planning 9 or medication usage. 4. Care plan audits will be done monthly by Nurse Manager or designee and submitted to Director of Nursing to be presented at quarterly QI meeting.	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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 16 the potential adverse drug interactions for the use of nine (9) or more medications for Resident #15. A review of the clinical record for +5 revealed a physician's order dated and signed June 19, 2008 and renewed without any changes on August 7, 2008 that included the following medications: Amlodipine Besylate, Furosemide, MVI (Multiple Vitamins), KCL (Potassium Chloride), Seroquel, Vitamin E, MPAP (Acetyl-Para-Aminophenol/Tylenol), Cosopt Eye Drops and Xalatan Eye Drops. A review of the care plan that was last updated on July 1, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #3 at approximately 9:30 PM on September 18, 2008. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on September 18, 2008.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team that includes the attending	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 17 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for five (5) of 30 sampled records, it was determined that facility staff failed to update care plans for: one (1) resident to include visitor activity; one (1) resident for multiple falls and code status; one (1) resident for a skin breakdown, fluid intake and falls; one (1) resident for integration of Hospice services; and one (1) resident for elopement risk. Residents #1, 2, 8, 13, and 27. The findings include: 1. Facility staff failed to update the elopement care plan for Resident #1 to include goals an approaches to protect resident from leaving the facility with unauthorized visitors. A review of the clinical record reveals a "Potential for Elopement" care plan initiated on August 11 2008. The goal states: "Resident will not leave unit unaccompanied by responsible party over next 30 days." The approaches documented:	F 280	**1.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Elopement care plan has been revised to include directions from responsible party regarding LOA instructions for Resident # 1. 2. All residents with special LOA instructions will be care planned. 3. Staff will be inserviced on residents with special LOA instructions. 4. Care plan audits will be done monthly by Nurse Manager or designee and submitted to Director of Nursing to be presented at quarterly QI meeting	10/1/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 18	F 280		

(1) Ensure resident is wearing "Watchmate" every shift and P.R.N..
(2) Picture at front desk.
(3) Sign out for Leave of absence (LOA) per protocol.
(4) Resident/staff education on leaving and protocol.
Evaluation documented :
"LOA [Leave of absence] with responsible party order obtained from Primary MD [Medical Doctor]"

A face-to-face interview was conducted with Employee #10 on September 19, 2008 at 11:00 AM. He/she stated that the Interdisciplinary Team (IDT) had concerns about Visitor
#1 taking the resident off premise and the possibility of having him/her withdraw funds from a bank account using an ATM (Automatic Teller Machine).

The resident's responsible party was his/her nephew/niece who lives out of state. Employee #10 stated, "I spoke with the responsible party on Monday (August 11, 2008) and shared our (IDT) concerns with [him/her]. The responsible party told me that it was okay for [Resident #1] to visit with [Visitor #1]. However, [responsible party] did not want [Visitor #1] to take [Resident #1] out of the facility."

The Leave of Absence form for Resident #1 indicated that the resident was signed out by Visitor #1 on the following days:
August 14, 2008 from 1:20 PM - 3:20 PM
August 14, 2008 from 5:10 PM - 6:30 PM
August 15, 2008 from 1:30 PM - 3:10 PM
August 18, 2008 from 12:25 PM - 2:00 PM
August 21, 2008 from 4:30 PM - 6:10 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 19 August 22, 2008 from 12:45 PM - 2:15 PM August 23, 2008 from 2:15 PM - 3:30 PM August 25, 2008 from 1:40 PM - 2:30 PM September 10, 2008 from 1:35 PM - 2:50 PM There was no evidence that the care plan was updated to reflect the responsible party's directions nor was a physician's order obtained. Additionally, all staff were not knowledgeable about who the resident could leave the facility with. The record was reviewed September 17, 2008. 2. Facility staff failed to update the care plans for Resident #2 for falls and code status. A. Facility staff failed to update the "Resident Sitting on the Floor" care plan and/or the "Fall risk indicator tool/Fall risk action plan" to include new goals and approaches for Resident #2 who had multiple falls without injury. A review of the IDT progress notes revealed the following: June 22, 2008 at 1920, "Resident was observed slipping to the floor ... no pain/injury was noted ..." June 24, 2008 at 0730, "...observed sitting in the bathroom on the floor ... no complaint of pain or discomfort." July 23, 2008 at 1930, "Charge nurse reported resident slid to floor in bathroom ...no apparent injuries ..." August 6, 2008 at 1500, "This writer was called at 1120 that the resident is on the floor ...no physical injury noted ..." A review of the "Fall risk indicator tool/Fall risk	F 280	**2A.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Resident # 2 care plan was updated to reflect new intervention. — 9/16/08 2. All Resident's Fall Risk Indicator Tool/ Fall Risk Action Plan will be reviewed and updated to reflect changes in the current interventions if necessary. — 11/3/08 3. Staff will be in serviced regarding updating Fall Risk Indicator Tool/ Fall Risk Action Plan after each fall to reflect current goals for prevention of further occurrences. — 11/3/08 4. Monthly fall audits will be done by QI and submitted to Director of Nursing for reporting to quarterly QI meeting. — 10/9/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 20 action plan" revealed the following: s/p [status post] fall May 24, 2008 - plan of care updated with new actions/approaches s/p fall May 28, 2008- no new actions/approaches to the current plan of care documented s/p fall June 24, 2008- plan of care updated with new action/approaches documented s/p fall July 23, 2008-- plan of care updated with new action/approaches documented s/p fall August 6, 2008- no new actions/approaches to the current plan of care documented The record lacked evidence that a "Fall risk indicator tool/fall risk action plan" was completed when the resident had a fall on June 22, 2008. Additionally, the "Fall risk indicator tool/Fall risk action plan" was not consistently updated/amended when Resident #2 was identified as having a fall. A face-to-face interview was conducted on September 16, 2008 at approximately 2:40 PM with Employee #4. He/she acknowledged that the plan of care for Resident #2 was not consistently updated each time the resident had a fall. The record was reviewed on September 16, 2008. B. Facility staff failed to update the "Code Status" care plan for Resident #2. A review of a telephone order dated February 12, 2008 directed, "1. Clarification of Code status. 2. D/c [discontinue] DNR 3. Pt [patient] is Full Code." A review of the Physician Order sheets for August 1, 2008 through September 30, 2008 and signed	F 280	**2B.) 483.20(d)(3), 483.10(k)(2)** **COMPREHENSIVE CARE PLANS** 1. Care plan was updated to reflect current Code status. 9/16/08 2. All residents records will be reviewed To ensure the code status is updated and Care planned. 11/3/08 3. Staff will be inserviced on updating and Care planning of code status. 11/3/08 4. Monthly audits will be done by Nurse Manager or designee and submitted to DON for reporting quarterly QI meeting. 10/9/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 21 by the physician on August 12, 2008 directed, " ...Advanced Directives: Full Code ..." A review of the Admission and Annual Physical Exam form completed May 5, 2008 revealed, " ... Advance Directives: DNR [do not resuscitate] ..." A review of the care plans revealed a DNR care plan and a full code care plan last updated August 5, 2008. The record lacked evidence that the Advance Directive care plans were updated with goals and approaches to address Resident #2's current code status. A face-to-face interview was conducted on September 16, 2008 at approximately 2:40 PM with Employee #4. He/she acknowledged that the aforementioned care plan(s) were updated to reflect the current code status for Resident #2. The record was reviewed on September 16, 2008. 3. Facility staff failed to update the care plans for Alteration in Skin Integrity, Hx (history)of UTI, and Resident at risk for falls for Resident #8. A. Facility staff failed to revise the "Alteration in Skin Integrity" care plan to include the open area to the right toe for Resident #8. A review of the care plan entitled "Alteration in Skin Integrity" last updated July 31, 2008 revealed "sacral, right ankle, and left lateral leg ulcers." A dressing change observation was conducted on September 14, 2008 at 11:32 AM with Employee	F 280	**3A.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Care plan was updated to reflect altered skin integrity on right toe for Resident # 8 2. All residents with altered skin integrity will be reviewed and updated. 3. Staff will be in serviced on the importance of updating care plans for skin alterations in skin integrity. 4. Monthly audits will be conducted by Nurse Manager or designee and submitted to Director of Nursing for reporting to quarterly QI meeting.	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 #15. An open area to the right 5th toe was observed. A face-to-face interview was conducted on September 16, 2008 at 3:55 PM with Employee #5. He/she "The sacral and the left leg ulcers are healed. The right ankle and the right 5th toe are the current open areas" . The record lacked evidence that the "Alteration in Skin Integrity" care plan was updated with goals and approaches to address the open area to the right toe. A face-to-face interview was conducted on September 16, 2008 at 3:55 PM with Employee #5. He/she acknowledged that aforementioned care plan was not updated to include the right toe. The record was reviewed on September 16, 2008. B. Facility staff failed to revise the "Hx of UTI [urinary tract infection]" care plan to include the current fluid intake for Resident #8. A review of the care plan Hx of UTI last updated July 31, 2008 revealed "Approach frequency ...Encourage and monitor fluid intake, up to 1800 ml per day ..." The physician's order dated September 15, 2008 directed, "Encourage po [by mouth] fluids up to 2500 ml/day..." The record lacked evidence that the Hx of UTI care plan was updated with goals and approaches to address the current order for fluid intake. A face-to-face interview was conducted on	F 280	**3B.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Care plan was updated to reflect current fluid 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 fluid intake 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	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 September 16, 2008 at 3:55 PM with Employee #5. He/she acknowledged that aforementioned care plan was not updated to include the current order for fluid intake. The record was reviewed on September 16, 2008. C. Facility staff failed to revise the "Resident at Risk for Falls" care plan after Resident #8 had a fall without injury. The nursing notes dated June 30, 2008 at 1930 [7:30 PM] revealed, "Resident was found in [his/her] room right side of [his/her] bed holding onto bed in kneeling position ..." The record lacked evidence that the "Resident at Risk for Falls" care plan last reviewed July 31, 2008 and the "Falls Risk Indicator Tool" was updated with goals and approaches to address the resident' s fall. A face-to-face interview was conducted on September 16, 2008 at 3:55 PM with Employee #5. He/she acknowledged that aforementioned care plan was not updated to include the fall. The record was reviewed on September 16, 2008. 4. Facility staff failed to integrate the hospice care plan for Resident #13. A review of Resident #13's record revealed a physician's order dated May 1, 2008 directing, "Refer to Palliative Care - End Stage Alzheimer's Disease." A care plan for palliative care was initiated the same day. A physician's order dated August 18, 2008 directed, "Refer to [Hospice Company] if family in agreement." The initial hospice assessment was	F 280	**3C.) 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Resident # 8 care plan and Fall Risk Indicator Tool was updated with goals and approaches to address her fall. 2. For all falls, the Fall Risk Indicator Tool/Fall Risk Action Plan will be completed and updated with goals and approaches to address fall. 3. Staff will be in serviced on importance of updating Fall Risk Indicator Tool/Fall Risk Action Plan after each fall with goals and approaches to address fall. 4. Monthly fall audits will be done by QI Nurse and submitted to Director of Nursing for reporting to quarterly QI meeting. **4. 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Hospice care plan was integrated with current care plan for resident # 13 2. There are three additional hospice care residents. Their plans of care were reviewed and integrated into the Hospice plan of care. 3. Staff will be in serviced on integrating hospice plan of care with resident's current plan of care. 4. Monthly care plan audits will be conducted by Nurse Manager or designee and submitted to Director of Nursing for presentation to quarterly QI meeting.	9/16/08 11/03/08 11/3/08 10/9/08 9/17/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. He/she stated, "It 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." 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. 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 note, "Resident wandered to 1st floor and sat in lobby."	F 280	**5. 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** 1. Resident # 27 Care Plan was revised and updated to ensure that resident will not not leave facility unaccompanied. 2. The care plan of all residents at risk for elopement, will be reviewed and updated. 3. Staff will be inserviced on Resident Elopement Prevention Policy 4. Monthly audits will be conducted by Nurse Manager or designee and submitted to Director of Nursing for reporting to quarterly QI meeting.	9/19/08 11/3/08 11/03/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 25 A third episode was documented in the nurse's notes on July 12, 2008. At 1320 [1:20 PM] a nurse documented, "Resident found on 4th floor in room 451." A review of the Watch Mate Care Plan revealed under "Problem - Resident will not wander and be re-directed as needed." The care plan lacked a start date to indicate when the plan was initiated. The goal for the problem was, "Resident will have no further wandering over next 90 days." The first goal date was June 19, 2008 and the second goal date was September 18, 2008. The approaches to attain the goal include: " Obtain a watch mate bracelet with assigned room number. Apply bracelet to resident. Escort resident to and from unit activities. The above listed goals were all a part of the initial undated care plan. Further review of the care plan failed to reveal any new goals or approaches to prevent additional episodes of elopement." A face-to-face interview was conducted with Employee #7 at approximately 9:30 AM on September 19, 2008. He/she acknowledged that the care plan lacked appropriate goals and approaches to prevent further episodes of elopement after the above cited episodes. The record was reviewed on September 19, 2008.	F 280		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled records, it was determined that facility staff failed to follow the approaches for the "Pain Management" care plan for Resident #11. The findings include: A review of the "Pain Management" care plan last updated July 15, 2008 revealed, "1. Assess and document for pain QSH [every shift] and PRN [as needed] utilizing pain scale." A review of the pain management flow sheet revealed that pain assessments were not conducted every shift. A face-to-face interview was conducted on September 19, 2008 at 9:50 AM with Employee #5. He/she acknowledged that the pain assessments were not conducted every shift. The record was reviewed on September 18, 2008.	F 282	**483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS** 1. Care plan for pain assessment for Resident # 11 was updated to reflect facility policy for monitoring chronic pain. 2. All residents with chronic pain will be Reviewed to ensure the facility pain Protocol to assess every eight hours was Adhered to. 3. Staff will be inserviced on the chronic pain protocol of assessing residents every eight hours. 4. Monthly pain audit will be done by Nurse Manager or designee and submitted to Director of Nursing to present in quarterly QI meeting.	9/19/08 11/3/08 11/3/08 10/9/08
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by:	F 286	**483.20(d) RESIDENT ASSESSMENT - USE** 1. Copy of MDS Assessments and previous closed record of March 31 was placed in current record.	11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 27 Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to maintain 15 months of Minimum Data Set (MDS) assessments on the resident's active record. Resident #5. The findings include: A review of Resident #5's current clinical record revealed the following: MDS Assessment reference date April 12, 2008, Section AA 8a was coded as 00 [indicating none of the above] and Section AA. 8b was coded as 5 [Medicare readmission/return assessment]. The MDS completed April 21, 2008, Section AA 8a was coded as 00 [indicating none of the above] and Section AA. 8b was coded as 7 [Medicare 14 day assessment]. A review of Resident #5's closed record revealed that he/she was discharged from the facility on March 31, 2008 and the physician completed a discharge summary on July 21, 2008. Upon review of Resident #5's closed record the admission MDS completed March 25, 2008 was maintained as a part of the closed record. A face-to-face interview was conducted on September 18, 2008 at approximately 10:00 AM with Employees #6, 16 and 17. They stated that the resident was discharged from the facility on March 31, 2008 with return anticipated. Resident #5 was readmitted to the facility on April 8, 2008 and a full MDS was completed [14 day assessment]. The facility staff acknowledged that the admission MDS in the closed record should	F 286	**(con't from page27)** **483.20(d) RESIDENT ASSESSMENT - USE** 2. Review all records of residents Currently receiving Medicare Part A Benefits and of other current residents who have received Medicare A benefits within the last 15 months to insure that 15 months of MDS Assessments are in the open record. 3. Facility policy has been revised to reflect consistent maintenance of hospitalized resident's medical records. All records will be considered open for a period of 30 days following a transfer to The hospital. Any resident whose stays exceeds 30 days will require a new chart upon the resident return to the facility. 4. Will monitor on a monthly basis and report to QI Committee 5. Completion date.	11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 28 have been on the current record. The record was reviewed on September 18, 2008.	F 286		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for eight (8) of 30 sampled residents and six (6) supplemental residents, it was determined that facility staff failed to: follow up on psychiatric and speech consults for weight loss and clarify a diagnosis for Diabetes Mellitus for one (1) resident; ensure one (1) resident received 2 liters of water daily; follow a safe swallowing guideline for one (1) resident; reassess pain during a dressing change for two (2) residents; ensure two (2) residents received medication; follow up on a psychiatric and pharmacist consult for weight loss for one (1) resident; follow orders for daily catheterization for one (1) resident; administer a nutritional supplement as per physician ' s orders for five (5) residents, administer medications as per physician's orders for three (3) residents and administer medications per manufacture's specifications for one (1) resident. Residents #3, 4, 6, 7, 8,13, 16, 28, JH1, JH2, JH3, JH5, JH6 and S1. The findings include:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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 received "Ca. [Calcium] and Vit. [Vitamin] D " recommended by the 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 7/14/08. 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	F 309	**1A.) 483.25 QUALITY OF CARE** 1. Psych consult and speech consults were completed for Resident # 3. 2. All residents identified with significant weight loss will be placed on the weight loss protocol which consist of consults by dietary, pharmacy and speech their weights are done weekly. 3. Staff will be reinserviced on the importance of following the weight loss protocol and to ensure the Speech, Pharmacy and Dietary consults are done. 4. Monthly weight loss audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present in quarterly QI meeting. **1B.) 483.25 QUALITY OF CARE** 1. Order written for Calcium and Vitamin D for Resident # 3. 2. All residents with pharmacy recommendations agreed by physician will be reviewed and carried out. 3. Staff will be in serviced on protocol for reviewing pharmacy recommendations. 4. Monthly consult audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting.	9/18/08 11/3/08 10/08/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 30 Consultant Pharmacist's Communication Report revealed that the physician checked the " agree " box indicating that he/she was in agreement with the pharmacist's recommendation and signed the form. However, review of the physician's orders and the Medication Administration Record (MAR) revealed that the Calcium and Vitamin D recommended by the pharmacist and agreed upon by the physician was never ordered for the resident. The finding was acknowledged by Employee #2 on September 19, 2008 at approximately 5:40 PM. The record was reviewed on September 16, 2008. 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)" report, the resident consumed the following amount of fluids: September 1, 2008 - 760 ml September 2, 2008 - 1360 September 3, 2008 - 1600 September 4, 2008 - 1120 September 5, 2008 - 1680 September 6, 2008 - 1720 September 7, 2008 - 1240 September 8, 2008 - 1480 September 9, 2008 - 1480 September 10, 2008 - 1480 September 11, 2008 - 1580	F 309	**2.) 483.25 QUALITY OF CARE** 1. Order was reviewed by physician and determined 1500 mL/ day fluid is adequate for resident # 4. 2. All residents with specific fluid intake orders will be reviewed and adhered to. 3. Staff will be in serviced on the importance of documenting PO fluid intake and what constitutes PO fluids. 4. Monthly intake and output audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present in quarterly QI meeting.	10/8/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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	F 309	**3.) 483.25 QUALITY OF CARE** 1. Resident # 7 was assessed by Speech Therapist and was determined that Safe Swallow Guide and plate guard was no longer needed. 2. All residents identified on a safe Swallow Guide will be reviewed to ensure the guides are adhered to. 3. Staff will be in serviced on the importance of adhering to Safe Swallow Guide instructions. 4. Monthly Safe Swallow Guide audit will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting.	10/8/08 11/03/08 10/09/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 April 114.0 May 109.0 June 106.4 July 109.0 August 111.6 A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:00 PM. He/she stated, "(Resident #7) no longer requires assistance or a plate guard. I should have discontinued this order long ago." The record was reviewed on September 16, 2008. 4. Facility staff failed to reassess Resident #8 for pain during the dressing change. A wound treatment observation was conducted on September 16, 2008 at 11:32 AM for Resident #8. During the dressing change to Resident #8's right ankle and right toe, Employee #15 raised the right leg of the resident remove the old visibly soiled dressing. At this time Resident #8 moaned and the employee continued to remove the dressing. After the dressing was removed, Employee #15 raised the right leg again to clean the right ankle, the resident moaned and continued to moan during the cleansing process. When Employee #15 raised the right leg to apply kling to the right ankle the resident moaned and yelled. Employee #5 [who entered the room during the dressing change] stated to the resident, "It's almost done." Employee #15 continued to apply tape to the dressing. During the dressing change Employee #15 failed to reassess Resident #8 for pain when he/she moaned during the dressing change.	F 309	**4.) 483.25 QUALITY OF CARE** 1. Resident # 8 was medicated for pain prior to dressing change, reassessed for pain during dressing change and medicated as needed. 2. Resident with dressing changes will be assessed for pain prior to and reassessed throughout the dressing change. 3. Staff will be inserviced on pain protocol for dressing changes. 4. Monthly treatment competencies will be done by the Wound Nurse and submitted to Director of Nursing for presenting to QI Committee meeting for review	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33 5. Facility staff failed to ensure that Resident #13 received the Os-cal D as ordered by the physician. A review of Resident #13's record revealed a "Consultant Pharmacist Communication" form dated August 5, 2008. The recommendation was , "This patient is taking Calcium Carbonate 600 mg po bid (twice daily, orally). Consider adding or switching to a supplement with vitamin D (eg. Os-cal D) to increase absorption of the calcium." The physician indicated under "Your Response - I agree" and wrote "Cal Vit D/Oscal BID[twice daily]." Facility staff failed to clarify the order and ensure that the resident received the Os-cal D twice daily. A face-to-face interview was conducted with Employee #5 on September 17, 2008 at 3:30 PM. He/she acknowledged that the resident had not received the Oscal. The record was reviewed September 17, 2008. 6. Facility staff failed to follow up on a psychiatric and pharmacy consult for weight loss for Resident #16. The physician's order dated June 16, 2008 directed, "... Psych Consult, Pharmacy Consult secondary to weight loss." According to the record, the Resident #16's weight was as follows: February, 2008 123.2 pounds March, 2008 120.2	F 309	**5.) 483.25 QUALITY OF CARE** 1. Order for OS-Cal D was clarified and administered per physicians orders for Resident # 13. 9/17/08 2. All residents with pharmacy recommendations, agreed by physician will be reviewed and carried out. 11/3/08 3. Staff will be in serviced on protocol for reviewing pharmacy recommendations. 11/3/08 4. Monthly consult audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting. 11/3/08 **6.) 483.25 QUALITY OF CARE** 1. Psych and Pharmacy consults were completed for resident # 16. 9/17/08 2. All residents identified for significant weight loss will be assessed and consults ordered will be done. 3. Staff will be reinserviced on the weight loss protocol and the important of ensuring the Pharmacy, Dietary and Speech consults are done. 4. Monthly weight loss audits will be done by Nurse Manager or designee and submitted to the Director of Nursing to present in quarterly QI meeting. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34 April, 2008 117.8 May, 2008 117.8 June, 2008 112.8 There was no evidence in the record that the psychiatric or pharmacy consults were completed at the time of this review. A face-to-face interview was conducted with Employee #7 on September 17, 2008 at 11:30 AM. He/she acknowledged that the psychiatric and pharmacy consults were not competed. The record was reviewed September 17, 2008. 7. Facility staff failed to correctly follow the physician order for In/out catheterization for Resident #28. An physician's interim order dated July 24, 2008 directed, "Intermittent catheterization PRN [as needed] and daily every HS [bed time] ..." A review of the Physicians Order Sheet dated and signed August 5, 2008 directed, "Intermittent catheterization PRN at HS daily for sensation of inability to void". A review of the Interdisciplinary Note and the Medication Administration Records from July 21, 2008 to September 18, 2008 lacked evidence that the resident received an In/out cath every HS. The record indicates the resident did receive In/out caths PRN. Additionally, the facility staff was unable to provide documentation of Input and Output records for this resident at time of survey. A face-to-face interview was conducted with	F 309	**7.) 483.25 QUALITY OF CARE** 1. Resident #28 catherization order was changed to intermittent catherizations when needed for sensation of inability to void. 2. All residents were reviewed for catherization orders. There is one resident who does self catherizations. 3. Staff will be in serviced on importance of following physicians order for catherization and assessing need for changes. 4. Monthly audits on MAR will be done on residents with catherization by Manager or designee and submitted to Director of Nursing for presentation at quarterly QI meeting.	9/18/08 11/308 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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 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.	F 309	**8.) 483.25 QUALITY OF CARE** 1. Order obtained to wrap ankle with kling and secure with tape for resident # S1. 2. Resident with dressing changes will be assessed for pain prior to and reassessed throughout the dressing change. 3. Staff will be in serviced on pain protocol for dressing changes. 4. Monthly treatment competencies will be done by wound nurse and submitted to Director of Nursing for presenting to QI meeting for review. **9.) 483.25 QUALITY OF CARE** 1. Resident # 6, JH1, JH3, JH5, and JH6 received correct dose of Beneprotein at their next med administration	9/17/08 11/3/08 11/3/08 10/9/08 9/16/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	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 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 mg two (2) tablets for his/her pain.	F 309	**(con't from page 36)** **9.) 483.25 QUALITY OF CARE** 2. All residents with Beneprotein powder orders will be assessed for correct dosages during Med pass. 3. Staff will be in serviced on correct measurements of Beneprotein powder. 4. Med pass audits will be done on staff every six months. Results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy meeting and QI meeting. **10A. 483.25 QUALITY OF CARE** 1. Order was obtained for pain medication for resident # JH2 and administered. 2. All residents identified with pain records will be reviewed to ensure there are orders for pain medication. 3. Staff will be in serviced on importance of obtaining physicians orders prior to administering medication. 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	11/3/08 11/3/08 10/9/08 9/16/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 37 A face-to- face interview was conducted at approximately 10:07 AM with Employee #24. He/she stated, "The Acetaminophen was administered to the resident for mild pain." The employee telephoned the physician for Acetaminophen to be given for pain. The records were reviewed September 16, 2008. B. Physician's order signed August 19, 2008 directed, "Megace 40 mg / ml administer 400 mg po [orally] daily for appetite stimulant." On September 15, 2008, at approximately 10:15 AM during the morning medication pass for Resident JH3, Employee #25 administered 12.5 ml of Megace, instead of 10 ml to Resident JH3. This observation was reported to Employee #6 on September 17, 2008 at approximately 3:30 PM. The records were reviewed September 17, 2008. C. Physician's order signed August 19, 2008 directed, "Acetaminophen 160 mg/5 ml, 20.3 ml (650 mg) per tube twice daily for comfort." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered 20 ml of Acetaminophen 160 mg/5 ml liquid, instead of 20.3 ml to Resident JH5. A face-to-face interview was conducted on September 19, 2008 at approximately 4:40 PM with Employee #4. He/she acknowledged that Acetaminophen not was administered as per physician orders. The records were reviewed September 17, 2008.	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 dosage 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 for 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 dosage 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 for review at quarterly pharmacy and QI meeting.	9/19/08 11/3/08 11/3/08 10/9/08 9/17/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 38 11. Facility staff failed to administer medication per manufacturer's specification for Resident JH5. The physician's order signed August 5, 2008 directed, "Nexium 40 mg capsule, [1] capsule per tube daily for GERD[Gastroesophageal Reflux Disease]." The manufactures insert under patient information for Nexium, stipulates "...Open capsule and empty the granules into a 60 ml catheter tipped syringe. Mix with 50 ml of water. Replace plunger and shake the syringe well for 15 seconds. Hold the syringe with the tip up and check for granules in the tip. Do not give the granules if they have dissolved or have broken into pieces..." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered Nexium via g-tube [gastric tube]. He/she opened the capsule into a medicine cup, add approximately 5 ml of water then poured it into the g-tube and flushed it with 5 ml of water. A face-to-face interview was conducted on September 19, 2008 at approximately 12:00 PM with Employee #4. He/she acknowledged that the Nexium was administered as per manufacturer's specification. The records were reviewed September 17, 2008.	F 309	**11.) 483.25 QUALITY OF CARE** 1. Manufacturers specification was followed during next med pass for resident # JH5. 2. All residents with medication orders requiring specific manufacturers instructions will be reviewed and adhered to. 3. Staff will be in serviced on following manufacturers specifications during medications administration. 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing to review at quarterly pharmacy and QI meeting.	9/18/08 11/3/08 11/3/08 10/9/08
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for two (2) of six (6) wound treatments, it was determined that facility staff failed to follow clean technique for wound dressing changes. Residents #8 and S1. The findings include: 1. Facility staff failed to follow the clean technique during the dressing change for Resident #8. A wound treatment observation was conducted on September 16, 2008 at 11:32 AM for Resident #8. Employee #15 washed hands and applied gloves that were removed from his/her right uniform pocket. The employee continued with the dressing change by removing the old visibly soiled dressing and discharging it into a clear bag inside the trash receptacle. The wound to the right ankle was cleaned and a new dressing was applied. Employee #15 proceeded to administer a treatment to the right 5th toe and again, placed the soiled dressing in the clear bag. During both treatments Employee #15 failed to place a barrier under the right foot and toe.	F 314	**1.) 483.25(c) PRESSURE SORES** 1. Clean techniques were followed for next dressing change for Resident # 8. 2. All residents identified with dressing changes will be observed by the wound care nurse to ensure clean techniques are followed. 3. Staff will be in serviced on clean technique for wound dressing change. 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation to quarterly QI meeting	9/16/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40 When the treatment was completed, Employee #15 disposed of the clear plastic bag in the biohazard trash receptacle located in the soiled utility room. Employee #15 then returned back to Resident #8's room to wash his/her hands instead of washing his/her hands at the sink in the soiled utility room. During the dressing change, there was no evidence that Employee #15 followed clean technique by removing and using gloves from his/her uniform pocket and not washing hands at the first available sink after discarding the soiled dressing. 2. A wound treatment observation was conducted on September 16, 2008 at 10:15 AM for Resident S1. Employee #14 failed to wash off the bed side table before placing 4 x 4 gauze pads, a bottle of normal sterile saline and a tube of Curosol gel in a plastic bag on top of the bed side table. The 4 x 4 gauze pads were in a plastic container. The container was opened and normal sterile saline was poured onto the gauze pads, which were left in the container. After removing the soiled dressing, Employee #14 cleansed the wound by placing the saturated 4 x 4 gauze pads on top of the wound twice. He/she failed to cleanse the right ankle Stage II pressure sore in a circular motion. Employee #14 opened the 2 x 2 gauze pads, left them in the outer wrapper and placed them into the 4 x 4 gauze pad container on top of the wet 4 x 4 gauze pads. When the treatment was completed, Employee #14 placed the unused 2 x 2 gauze pads and	F 314	**2.) 483.25(c) PRESSURE SORES** 1. Clean technique was followed for next dressing change for Resident # S1. 2. Clean technique was followed for all residents with dressing changes. 3. Staff will be in serviced on clean technique for wound dressing changes. 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation to quarterly QI meeting.	9/17/08 11/3/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 41 bottle of normal sterile saline from the room back into the treatment cart. The soiled wound dressings were placed in a clear plastic bag and disposed of in non-biohazard trash.	F 314		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a safe environment and supervise residents as evidenced by: attempt to light the gas burner with paper, multiple outlet strips on the floor, glass vases stored unsafely, unsecured lamp covers in residents' rooms, unsecured HVAC (Heating, Ventilation and Cooling) unit covers, worn walking surface between the parallel bars, medications left unattended, one (1) resident who had multiple falls, one (1) resident who had unauthorized leaves of absence and one (1) resident who eloped multiple times. Residents #1, 2 and 27. The findings include: 1. Facility staff attempted to light a gas burner with a piece of paper. During the tour of the main kitchen on September 15, 2008 at approximately 10:15 AM, the one (1)	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 42 of the six (6) burner oven failed to light. Employee #13 was asked what method was used to light the burner. Employee #13 tore a piece of paper off paper located on the cook's preparation table and attempted to light the burner. Employee #13 acknowledged that there was no procedure in place for lighting the gas burner when the burner did not automatically light. 2. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, mulit-plug outlet strips were observed on the floor in rooms 405, 555, and 5 East clean utility room and the 1st floor pantry floor outlet lacked a cover in four (4) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 3. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, four (4) glass vases were observed stored on the floor in room 314 near the bathroom door, in the walking path and one (1) glass vase was stored on the top shelf above the bed in room 510 in two (2) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 4. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, the ceiling lamp covers were not secured to the fixture in rooms 347, 502 and 523 in three (3) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations.	F 323	**1.) 483.25(h) 483.25(h) ACCIDENTS AND SUPERVISION** 1. The Maintenance department was notified to immediately lite the burner. 9/15/08 2. All burners were inspected. 9/15/08 3. Employees attended a meeting on the importance of notifying the Maintenance dept. to lite burners if they fail to lite An inservice will be held on the proper procedures. The manager will monitor compliance. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-going **2.) 483.25(h) 483.25(h) ACCIDENTS AND SUPERVISION** 1. All multi-plug outlets were secured to the Walls and the covers were replaced. 9/16/08 2. All other multi-plug outlets and covers were inspected, secured and covers replaced where needed. 9/24/08 3.. Monitor the multi-plug outlets and covers covers and take corrective action as needed. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-going **3.). 483.25(h) ACCIDENTS AND SUPERVISION** 1. Glass vases were immediately removed from room 314 and 510. 9/15/08 2. All residents rooms were checked for Hazardous items. 11/3/08 3. Staff will be inserviced on the guidelines of F-tag 323 Accidents and Supervision and will conduct environmental rounds every shift to ensure a resident safe environment. 11/3/08 4. Environmental rounds will be done every shift, and submitted to Director of Nursing quarterly for review in the quarterly QI meeting. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43 5. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, HVAC covers were not secured in rooms 502 and 523 in two (2) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 6. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, the walking surface between the parallel bars in the Rehabilitation area on the 3rd floor was worn and skid strips were not secured to the walking surface in one (1) of one (1) set of parallel bars observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 7. On September 16, 2008 at approximately 9:10 AM during the medication pass for Resident #6, from approximately 9:15 AM until 9:18 AM, Employee #24 left all of the residents' medications on the medication cart unattended to retrieve Beneprotein from the medication room. At approximately 9:20 AM he/she left all the medication on the cart to sanitize her hands in the resident's room. The following medications were left on the medication cart: Buderprion SR 100mg [1] tablet, Colace 100 mg [1] capsule, Zinc 50 mg [1] capsule, Vitamin C 500 mg [1] tablet, Cyclobenzaprine 10 mg [1] tablet, Oystershell Ca plus Vitamin D 500mg/200mg [1] tablet , Ferrous Sulfate 325 mg tablet [1] tablet, Amlodipine 10 mg [1] tablet, Multivitamin [1] tablet, Meclizine 12.5mg [1] tablet, Spiriva 18 mcg Handihaler [1] capsule, Cospt eye drops, and Advair 500/50 MDI.	F 323	**4.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. The ceiling lamp covers were secured to the Fixtures. 9/19/08 2. All other ceiling lamp covers were inspected and secured to the fixtures as required. 9/22/08 3.. Monitor the condition of the ceiling lamp covers and take corrective action as needed. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-going **5..) 483.25(h) ACCIDENTS AND SUPERVISION** 1. The HVAC covers were secured immediately. 9/15/08 2. All other HVAC covers were inspected and secured as required. 9/22/08 3. Inservice staff on guidelines of F-tag 323 Accidents and Supervision. The HVAC covers Will be monitored and corrective action will be Taken as needed. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-going **6.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. The platform was cleaned and all worn Tape was removed. The platform will be Sanded in order to restore the surface. New Skid tape will be applied to the walking surface Of the parallel bars in a perpendicular fashion. 10/24/08 2. An inspection of all training stairs, parallel Bars, standing tables and any areas requiring Antiskid support was performed from 9/16/08 Thru 9/19/08. All areas showing evidence of Worn tape were replaced with new antiskid tape 3. All physical therapy and occupational Therapy associates were counseled on the Safety risks that exist by not having these Surfaces secured. This topic will also be an Agenda item at the 10/31/08 Rehabilitation Services Staff Meeting, i.e., F-tag 323 Accidental and Supervision. 4. The Director will report monitoring results And corrective actions to the QI quarterly Meeting. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 44 A face-to-face interview was conducted at that time of the observation with Employee #24. He/she acknowledged that the medications were left on the medication cart unattended. 8. Facility staff failed to provide adequate supervision to ensure that Resident #1 did not leave the facility with an unauthorized visitor. A face-to-face interview was conducted with Employee #10 on September 19, 2008 at 11:00 AM. He/she stated that the Interdisciplinary Team (IDT) had concerns about Visitor #1 taking Resident #1 off the premise and the possibility of having Resident #1 withdraw funds from a bank account using an ATM (Automatic Teller Machine). The resident's responsible party was his/her nephew/niece who lives out of state. Employee #10 stated, "I spoke with the responsible party on Monday (August 11, 2008) and shared our (IDT) concerns with [him/her]. The responsible party told me that it was okay for [Resident #1] to visit with [Visitor #1]. However, [responsible party] did not want [Visitor #1] to take [Resident #1] out of the facility." A review of Interim physician orders revealed an order obtained from Primary MD [Medical Doctor] on August 11, 2008 "LOA [Leave of absence] with responsible party." The Leave of Absence form for Resident #1 indicated that the resident was signed out by Visitor #1 on the following days: August 14, 2008 from 1:20 PM - 3:20 PM August 14, 2008 from 5:10 PM - 6:30 PM	F 323	**7.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. Employee # 24 was observed on next Med pass to ensure that medications were not left on cart unattended. 2. All licensed staff will be observed during Med pass to ensure that medications are not left on cart unattended. 3. Staff will be in serviced on med pass safety. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meeting. **8.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. As directed by the POA, Resident # 1 is not to leave the facility with unauthorized visitors. 2. All residents identified with visitor restrictions will be reviewed with staff. 3. Staff will be in serviced on LOA Policy. 4. Resident LOA plan of care will be reviewed at quarterly IDT conference and care plan audits will be done and submitted to Director of Nursing for presentation at quarterly QI meeting.	9/16/08 11/3/08 11/3/08 11/3/08 10/8/08 9/16/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 45 August 15, 2008 from 1:30 PM - 3:10 PM August 18, 2008 from 12:25 PM - 2:00 PM August 21, 2008 from 4:30 PM - 6:10 PM August 22, 2008 from 12:45 PM - 2:15 PM August 23, 2008 from 2:15 PM - 3:30 PM August 25, 2008 from 1:40 PM - 2:30 PM September 10, 2008 from 1:35 PM - 2:50 PM The record lacked evidence that the facility provided supervision to ensure that Resident #1 did not leave the facility with Visitor #1. The facility failed to put a process in place and adequately supervise Resident #1 to prevent the resident from leaving the facility with Visitor #1 and to assure that all applicable staff are knowledgeable about whom the resident can leave facility with. A face-to-face interview was conducted with Employee #10 on September 19, 2008 at approximately 11:00 AM. Employee #10 acknowledged the above findings. 9. Facility staff failed to supervise Resident #2 who had multiple falls without injury. A review of the IDT progress notes revealed the following: June 22, 2008 at 1920 (5:20 PM), "Resident was observed slipping to the floor ... no pain/injury was noted ... " June 24, 2008 at 0730, " ...observed sitting in the bathroom on the floor ... no complaint of pain or discomfort. " July 23, 2008 at 1930 (5:30 PM), " Charge nurse reported resident slid to floor in bathroom ...no apparent injuries ... "	F 323	**9.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. Resident # 2 care plan was updated to reflect new intervention. 9/16/08 1. All residents fall risk indicator tools/fall risk action plan will be reviewed and updated to reflect changes in the current Interventions if necessary. 11/3/08 3. Staff will be in serviced regarding updating Fall Risk Indicator Tool/Fall Risk Action Plan after each fall to reflect current goals for prevention of further occurrences. 11/3/08 4. Monthly fall audits will be done by QI and submitted to Director of Nursing for reporting to quarterly QI meeting. 10/9/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 46 August 6, 2008 at 1500 (3:00 PM), " This writer was called at 1120 that the resident is on the floor ...no physical injury noted ... " A review of the " Fall risk indicator tool/Fall risk action plan " revealed the following: s/p [status post] fall May 24, 2008 - plan of care updated with new actions/approaches s/p fall May 28, 2008- no new actions/approaches to the current plan of care s/p fall June 24, 2008- plan of care updated with new action/approaches s/p fall July 23, 2008-- plan of care updated with new action/approaches s/p fall August 6, 2008- no new actions/approaches to the current plan of care The record lacked evidence that a "Fall risk indicator tool/fall risk action plan" was completed when the resident had a fall on June 22, 2008. Additionally, the "Fall risk indicator tool/Fall risk action plan" was not consistently updated/amended when Resident #2 was identified as having a fall. There was no evidence that after each fall the facility staff initiated interventions to prevent the resident from falling. A face-to-face interview was conducted on September 16, 2008 at approximately 2:40 PM with Employee #4. He/she acknowledged that the plan of care for Resident #2 was not consistently updated each time the resident had a fall. The record was reviewed on September 16, 2008. 10. Facility staff failed to follow the facility's policy for elopement for Resident #27.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 47 The facility's Policy #1207 titled "Elopement of A Resident" revealed, "...Item #6 ..."Once the resident is found, Communications will take a picture of the resident and place in the lobby." An observation of the receptionist's desk in the lobby at approximately 6:30 PM on September 18, 2008 and on September 19, 2008 at approximately 10:00 AM failed to reveal a picture of Resident #27. A face-to-face interview was conducted with Employee #7 at the time of the observation. He/she acknowledged that there was no picture of the resident at the receptionist's desk. He/she added, "I will place it there immediately." The record and policy was reviewed on September 19, 2008.	F 323	**10.) 483.25(h) ACCIDENTS AND SUPERVISION** 1. Resident # 27's picture was placed at the receptionist's desk. 2. All resident identified as elopement risks have their pictures placed at the Receptionist desk. 3. Staff will be in serviced on elopement policy. 4. Care plan audits will be done monthly by Nurse Manager or designee and submitted to Director of Nursing to be presented to quarterly QI meeting	9/19/08 11/3/08 11/3/08 11/3/08
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three(3) of eight (8) sampled residents observed during medication pass, it was determined that facility staff did not ensure a medication error rate less than five (5) percent during the medication pass. Residents JH2, JH3 and JH5. The findings include: Licensed staff failed to ensure that the facility was	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 48 free of a medication error rate of 5% or greater. The medication error rate for the facility was 7.4% based on the results of the medication passes observed on September 16 and 17, 2008. 54 opportunities were observed with four (4) non-significant errors. 1. The facility staff failed to administer Acetaminophen as per physician's orders for Resident JH2. 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. A face-to-face interview was conducted at approximately 10:07 AM with Employee #24. He/she stated, "The Acetaminophen was administered to the resident for mild pain." The physician was telephoned for a verbal order of Acetaminophen to be given for pain. The records were reviewed September 16, 2008. 2. The facility staff failed to administer Megace as per physician's orders for Resident JH3. Physician's order signed August 19, 2008 directed, "Megace 40 mg/ml suspension, administer 400 mg po daily for appetite stimulant."	F 332	**1.) 483.25(m)(1) MEDICATION ERRORS** 1. Order was obtained for pain medication for Resident # JH2 and administered. 9/16/08 2. Staff will obtain orders for resident prior to administering medication. 11/3/08 3. Staff will be in serviced on importance of obtaining physician orders prior to administering medication. 11/3/08 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08 **2.) 483.25(m)(1) MEDICATION ERRORS** 1. Resident # JH3 received correct dose of Megace at next med pass. 9/19/08 2. All residents with liquid medication orders will be assessed for correct dosage measurement during med pass. 11/3/08 3. Staff will be in serviced on correct measurement of liquid medication. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 49 On September 15, 2008, at approximately 10:15 AM during the morning medication pass for Resident JH3. Employee #25 administered 12.5 ml of Megace, instead of 10 ml to Resident JH3. The findings were reported in a face-to-face interview which was conducted on September 17, 2008 at approximately 3:30 PM with Employee #6. The records were reviewed September 17, 2008. 3. The facility staff failed to administer Acetaminophen as per physician's orders and Nexium as per the manufactures recommendations for Resident JH5. A. Physician's order signed August 19, 2008 directed, "Acetaminophen 160 mg/5 ml, 20.3 ml (650 mg) per tube twice daily for comfort." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5. Employee #14 administered 20 ml of Acetaminophen 160 mg/5 ml liquid, instead of 20.3 ml to Resident JH5. A face-to-face interview was conducted on September 19, 2008 at approximately 4:40 PM with Employee #4. He/she acknowledged that Acetaminophen not was administered as per physician orders. The records were reviewed September 17, 2008. B. Facility staff failed to administer medication per manufacturer's specification for Resident JH5. The physician's order signed August 5, 2008 directed, "Nexium 40 mg capsule, [1] capsule per	F 332	**3A.) 483.25(m)(1) MEDICATION ERRORS** 1. Resident JH5 received correct dose of Tylenol at next medication pass. 2. All residents with liquid medication orders will be assessed for correct dosage measurement during medication pass. 3. Staff will be in serviced 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 for review at quarterly pharmacy and QI meeting. **3B.) 483.25(m)(1) MEDICATION ERRORS** 1. Manufacturer's specification was followed during next med pass for resident #JH5. 2. All residents with medication orders requiring specific manufacturers instructions will be reviewed and adhered to. 3. Staff will be in serviced on following manufacturers specification during medication administration. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meeting.	9/19/08 11/3/08 11/3/08 11/3/08 9/18/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 50 tube daily for GERD[Gastroesophageal Reflux Disease]." The manufactures insert under patient information for Nexium, stipulates "...Open capsule and empty the granules into a 60 ml catheter tipped syringe. Mix with 50 ml of water. Replace plunger and shake the syringe well for 15 seconds. Hold the syringe with the tip up and check for granules in the tip. Do not give the granules if they have dissolved or have broken into pieces..." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered Nexium via g-tube [gastric tube]. He/she opened the capsule into a medicine cup, add approximately 5 ml of water then poured it into the g-tube and flushed it with 5 ml of water. A face-to-face interview was conducted on September 19, 2008 at approximately 12:00 PM with Employee #4. He/she acknowledged that the Nexium was administered as per manufacturer's specification. The records were reviewed September 17, 2008.	F 332	**483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES** 1.Resident # 7 was assessed by the Speech Therapist and she determined that Safe Swallow Guide and plate guard was no longer needed. 2. All residents identified on a Safe Swallow Guide will be reviewed to ensure the guides are adhered to. 3. Staff will be in serviced on the importance of adhering to Safe Swallow Guide instructions. 4. Monthly Safe Swallow Guide audit will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting.	10/8/08 11/3/08 11/3/08 11/3/08
F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to provide an	F 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 369	Continued From page 51 assistive device for Resident #7 for meal time. The findings include: 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. The resident consumed all the food followed by all the liquids without difficulty. A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:00 PM. He/she stated, "(Resident #7) no longer requires assistance or a plate guard. I should have discontinued this order long ago." The record was reviewed on September 16, 2008.	F 369	**1.) 483.35(i) SANITARY CONDITIONS** 1. The outside surfaces of the mixer, combi-Stove, outside surfaces of the tilt grill, outside Of the steam kettle, top surfaces of the gas Oven, compressor fan of the ice machine, Outside of the convention oven, outside of Popcorn 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 debris, outside of the Dish machine by the detergent dispenser were All cleaned. 2.. All surfaces were inspected and cleaned as needed. 3.. All Food Service equipment will be placed on routine cleaning schedules. The Department Director and the Quality Coordinator will monitor compliance and ensure cleanliness. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A copy of this report will be submitted to the Administrator monthly.	9/14/08. 11/3/08 11/30/08 On-going
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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: 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 reuse. These findings were observed in the presence of Employees #13 and 21 on September 15, 2008 from 8:40 AM through 11:30 AM. The findings include: 1. The outside surfaces of the following appliances were soiled with accumulated grease and debris: mixer, Combi-stove, outside surfaces of the tilt grill, outside of the steam kettle, top surfaces of the gas oven, compressor fan of the ice machine, outside of the convection oven, outside of popcorn 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 debris, outside of the dish machine by the detergent dispenser,	F 371	**2.) 483.35(i) SANITARY CONDITIONS** 1.The floor and grout between the floor tiles throughout the kitchen, cove base and corners, walls by the grease trap, the drain by the three (3) compartment sink, the back splash by the three (3) compartment sink, area underneath three (3) compartment sink, and area under dish disposal were all cleaned. 2.. All other areas were inspected and cleaned as needed. The floor and wall areas will be placed on routine cleaning schedules and checked by the supervisors for cleanliness. 3. The supervisors will check to see if the kitchen areas have been clean and document findings on the evening check list. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A copy of this report will be submitted to the Administrator monthly. **3.) 483.35(i) SANITARY CONDITIONS** 1. The Hood filters were removed and cleaned thoroughly. 2. The supervisors will check the hood for cleanliness weekly. All unsatisfactory hoods will be cleaned. 3. Hood Filters will be placed on a routine cleaning schedule and check by the supervisors. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A copy of this report will be submitted to the Administrator monthly.	9/14/08 On-going 9/14/08. On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 53 accumulated dust on top of the dish machine, and the electric boxes above the dish machine with accumulated dust. 2. The floor and grout between the floor tiles throughout the kitchen, cove base and corners were soiled with accumulated debris and grease. Walls by the grease trap, the drain by the three (3) compartment sink, the back splash by the three (3) compartment sink, area underneath three (3) compartment sink, and area under dish disposal were observed soiled with accumulated grease and debris. 3. Seven (7) of seven (7) cooking hood filters were soiled with accumulated dust, grease and debris. 4. The following unlabeled/undated food items were observed in the freezer, walk-in refrigerator and cook's holding box: Freezer: 4 packages of chicken livers, 2 packages of scones, and 4 packages of chicken with 2 whole chickens in each package. Walk in refrigerator: 8 packages of beef stew, 2 packages of chopped ham, 2 cases of chicken, container of sliced oranges, 1 cooked omelet in a plastic container, 1 box glorious morning muffin batter, 1 box blueberry muffin batter, 2 packages of shredded lettuce, open package of green peppers, and 135 Strawberry Shakes with no thaw date and marked on the sided of each container "After thawing, keep refrigerated. Use within 14 days of thawing." Cook's holding box: package of French toast (12 pieces), 1 package of open bacon, and 1	F 371	**4.. 483.35(i) SANITARY CONDITIONS** 1. All unlabeled and undated items were Immediately dated and the ones that could not labeled were discarded. 2. All opened food items in the storage areas were inspected and labeled. 3. Supervisors will check storage areas daily to see if foods items are properly labeled. An in-service on properly labeling food items will be given by the Food Service Director. 4.. The Quality Coordinator will visit the kitchen every 10 days to check compliance. All findings will be reviewed by the Department and plan of action will be developed for noncompliant items. This report will be submitted to the administrator monthly. **5.) 483.35(i) SANITARY CONDITIONS** 1.The water was removed from thawed trays. 2.. All trays were inspected to ensure they were dry.. The supervisors will monitor closely the thawing procedures in the kitchen and correct if necessary. 3. An in-service on proper thawing of food items will be given by the Food Service Director. 4.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 develop for noncompliant items. This report will be given to the Administrator monthly . **6.) 483.35(i) SANITARY CONDITIONS** 1.The celery was immediately discarded . 2.. All produce was inspected for satisfactory appearance.. All unsatisfactory produce was discarded or returned to the seller. 3. All produce will be checked daily by the supervisors for a satisfactory appearance. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/16/08 9/16/08 On-going 9/16/08 9/16/08 10/25/08 9/16/08 ???? 10/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 54 container of beef flavoring. 5. Approximately 1-2 inches of water accumulated on two (2) trays where cartons of scrambled egg mix were stored, with 13 cartons on one tray and 10 cartons one tray in the walk-in refrigerator. 6. A bin of several bunches of celery with brown spots on stalks and wilted leaves in the walk-in refrigerator. 7. Items in the dry storage area were undated. 8. The two (2) cook's preparation sinks were filled with chicken parts that were thawing and covered with ice. 9. The following hotel pans were stored wet with a greasy residue and ready for reuse: Nine (9) 1/3 hotel pans, seven (7) 2 inch hotel pans, 18 ¼ hotel pans, 17 ½ hotel pans, and 22 full size hotel pans. 10. There was no evidence that the pH for the sanitizer and water temperature for washing and sanitizing were monitored at the three (3) compartment sink. 11. There were no air gaps or back flow prevention valves for the two (2) sinks by cook's prep area. 12. The drain cover by three (3) compartment sink was not secured and the interior was soiled. 13. The designated trash cans for the two (2) hand washing sinks required lifting lid to place paper towels in it.	F 371	~~T2.)483.35(i) SANITARY CONDITIONS~~ 1.All items in the dry storage containers were labeled and dated immediately. 2. Supervisors will check all dry storage areas and label all unlabelled items. 3.A daily walk through of the dry storage areas by the supervisors will done to monitor compliance 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 develop for noncompliant items. This report will be given to the Administrator monthly . **8.) 483.35(i) SANITARY CONDITIONS** 1. The cook was immediately instructed regarding proper thawing techniques and the chicken parts were immediately discarded. 2.. The area was inspected to ensure that no other chicken parts were thawing , covered in ice. All cooks were instructed on proper handling of thawing techniques. 3. In-services were given to staff by the Food Services 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 develop for noncompliant items. This report will be given to the Administrator monthly. **9.) 483.35(i) SANITARY CONDITIONS** 1. The entire rack of pans were immediately cleaned by the dish machine. 2.. All pots and pans were inspected and Cleaned on the hotel pan rack, as needed. 3. An in service will be given by the Food Service Director to staff on proper cleaning of pans. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/16/08 On-going 9/15/08. 9/27/08 10/25/08 9/15/08. 9/27/08 10/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 55 14. Employee #20 was observed carrying two (2) hotel pans of cooked hamburgers in one hand and a floor mop in other. The employee laid the mop against the counter while placing meat on same counter. 15. The floor mop was observed leaning against sink by the cook's preparation area where food was being prepared. 16. Employee #19 was observed carrying the floor mop towards the walk-in refrigerator through the area where food was being prepared. 17. Sanitizer towels were sitting open on counter where macaroni and spaghetti were located and across a food preparation area. 18. Employee #20 was observed transferring rice from a cooking to serving vessel without gloves at approximately 10:50 AM. 19. Employee #21 was observed filling dessert dishes with fruit. The employee was observed removing one (1) glove, retrieved a sanitation card from his/her ID holder, handed it to supervisor, and did not wash hands before replacing glove and returned to filling the dessert dishes. 20. Four (4) brooms and two (2) push brooms were observed on floor of janitorial closet in the main kitchen. These observations were acknowledged by Employee #13 at the time of the observations. 21. Nine (9) of nine (9) cans of Nepro supplement had an expiration date of April 1, 2008 in the 3rd	F 371	**10.) 483.35(i) SANITARY CONDITIONS** 1. The water was tested using test strips for proper pH and documented. 2. All testing documentation will be placed on the pH testing log and monitored by supervisor. 3. An in-service is scheduled by ECOLAB. 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 develop for noncompliant items. This report will be given to the Administrator monthly. **11.) 483.35(i) SANITARY CONDITIONS** 1. Maintenance was contacted and a back Flow valve was installed immediately. 2.. All other sink areas were inspected and corrected as needed. This will be monitored by supervisors. 3.Results will be submitted to the Director. 4. A report will be presented quarterly to the QI committee. **12.) 483.35(i) SANITARY CONDITIONS** 1. The drain cover was cleaned. 2.. All other drains were inspected and cleaned as needed. This is monitored by supervisors. 3. An in-service will be given 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 develop for noncompliant items. This report will be given to the Administrator monthly. **13.) 483.35(i) SANITARY CONDITIONS** 1. The lidless trash cans were placed by sink and the employee rewashed their hands. 2.. All employees instructed to use lidless trash cans after washing their hands. This is 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/15/08. 10/27/08. 10/25/08 9/22/08 9/22/08 On-going 9/15/08. 10/27/08. On-going 9/15/08 10/27/08. 10/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 56 floor pantry. 22. Four (4) of four (4) cartons of skim milk and one (1) of five (5) cartons of whole milk with expiration date of September 12, 2008 in the 3rd floor pantry and seven (7) of 11 cartons of skim milk with an expiration date of September 12, 2008 in the 5th floor pantry. 23. Food transport cart observed soiled and with a cracked top shelf in the 1st floor pantry. 24. 19 of 42 dinner plates observed wet and ready for reuse in the 1st floor pantry.	F 371	**14.) 483.35(i) SANITARY CONDITIONS** 1. The cooked hamburgers were thrown away. The employee was immediately corrected. 2.. All employees were instructed by the Food service Director about preventing cross contamination. 3. An in service will be given by Food Service Director on preventing cross contamination. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/15/08 9/27/08 10/25/08
F 386 SS=E	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for seven (7) of 30 sampled residents, it was determined that the physician failed to review the total plan of care for six (6) residents and include the current advanced directive on the history and physical (H&P) for one (1) resident. Residents #2, 4, 5, 7, 10, 13, and 16. The findings include:	F 386	**15.) 483.35(i) SANITARY CONDITIONS** 1. The mop was removed and area sanitized. 2. The cooks were instructed by the Food Svc. Director of the importance of preventing cross contamination. 3.An in service will be given by Food Service Director on prevention of cross contamination. 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 develop for noncompliant items. This report will be given to the Administrator monthly. **16.) 483.35(i) SANITARY CONDITIONS** 1. Employee was instructed to take another path 2. All staff were instructed to take another path outside of the prep areas to prevent cross contamination. 2. An in service will be given on prevention of cross contamination by Food Service 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 develop for noncompliant items. This report will be given to the Administrator monthly. **17.) 483.35(i) SANITARY CONDITIONS** 1. Sanitizer towels were removed from food preparation area and the food preparation area was cleaned with a sanitizer.	9/14/08 9/27/08 10/25/08 9/16/08 9/16/08 9/27/08 10/25/0 9/19/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 57 1. Physician #1 failed to review the total plan of care for the following residents: A. The physician failed to include falls in the plan of care when the plan of care was reviewed for Resident #2 who had multiple falls without injury. A review of the IDT [interdisciplinary team] progress notes revealed the following: June 22, 2008 at 1920, "Resident was observed slipping to the floor ... no pain/injury was noted ..." June 24, 2008 at 0730, "...observed sitting in the bathroom on the floor ... no complaint of pain or discomfort." July 23, 2008 at 1930, "Charge nurse reported resident slid to floor in bathroom ...no apparent injuries ..." August 6, 2008 at 1500, "This writer was called at 1120 that the resident is on the floor ...no physical injury noted ..." The record lacked evidence that the attending physician reviewed the resident's fall status. A face-to-face interview was conducted on September 16, 2008 at approximately 2:40 PM Employee #4. He/she acknowledged that the attending physician failed to include the falls in the review of the plan of care. The record was reviewed on September 16, 2008. B. A review of Resident #4's record revealed the following nurse' s notes: May 27, 2008 at 1100 " Reddened area with a dry scab over the right gluteus area ..." The resident's weight in March 2008 was 166.4 pounds and in May 2008 was 157.2 pounds. The	F 386	**(con't from page 57)** **17.) 483.35(i) SANITARY CONDITIONS** 2. Food Service Director instructed staff on the Prevention of food contamination on prep areas. 3. An in- service will given by Food Service Director. 10/11/08 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **18.) 483.35(i) SANITARY CONDITIONS** 1. The associate was instructed to wear gloves when handling ready to serve foods. 9/19/08 2. All employees were instructed by Food Service Director to wear gloves when handling ready to serve foods. This is monitored daily by supervisors. 3. An in service will be given to staff by Director. 10/11/08 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **19.) 483.35(i) SANITARY CONDITIONS** 1. Employee was instructed by Director to wash hands immediately and change gloves. 9/15/08. 2..All employees were instructed on proper usage of gloves when preparing foods. 3. An in service will be given by Food Svc. Director on proper usage of gloves when handling foods. 9/27/08. 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **20.) 483.35(i) SANITARY CONDITIONS** 1. All brooms were immediately hung in the janitorial closet. 9/15/08 2..Supervisors will monitor daily to see if the brooms are hung properly in the janitorial closet. 3. An in-service will be given on the importance of hanging broom properly in the closet by the Director. 10/11/08. **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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 58 resident lost 9.2 pounds in two (2) months. Physician #1's note dated June 9, 2008 documented, "Pt. without distress; Chart/orders reviewed and signed; vital signs stable, afebrile; physical exam unchanged; plan stable, continue present meds and treatments." Physician #1 failed to address the resident's skin condition and weight loss. A face-to-face interview was conducted with Physician #1 on September 15, 2008 at 10:30 AM. He/she acknowledged that the note did not reflect the resident's status. The record was reviewed September 15, 2008. C. A review of Resident #7's record revealed the following nurses' notes: July 2, 2008 at 1300, "Resident hit another resident at the same table ..." July 3, 2008 at 0630, "Resident was confused talking non-related matter and taking [his/her] clothes off. Also throwing pillows and sheets ..." A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:00 PM. He/she stated," The resident had moments of resisting care, but in July (2008) [he/she] had a couple of days of really bizarre behavior." The resident had the following weights for 2008: April 114 pounds May109 pounds June 106.4 pounds July 109 pounds Physician #1's note dated July 3, 2008,"Patient seen and examined, vital signs stable, afebrile,	F 386	**21.) 483.35(i) SANITARY CONDITIONS** 1. All expired Nepro cans were discarded. 9/16/08 2.. The pantries were inspected and all expired cans were discarded. This is monitored daily by Supervisors. 3. Food Service Director instructed staff on the Importance of discarding expired supplements. 9/27/08 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **22.) 483.35(i) SANITARY CONDITIONS** 1. All expired milk was discarded immediately. 9/16/08 2.. All pantries were inspected and all expired milk was discarded. This is monitored daily. 3. An in-service was given to staff by Director. 9/27/08 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **23.) 483.35(i) SANITARY CONDITIONS** 1. The food transport cart and tray were discarded. 9/15/08 2.. All food trays and carts were inspected and cleaned as needed. This is monitored daily. 3. Staff instructed by Director to use clean carts with prepared food. 9/27/08 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 develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **24.) 483.35(i) SANITARY CONDITIONS** 1. The employee was instructed to stop using the wet plates and to use dry plates only. 9/19/08 2.. All dinner plates were inspected and dried as needed. This is monitored daily 3.. All employees were instructed to use dry plates during meal service. 9/27/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 59 chart/orders reviewed and signed, latest lab - BUN/CR 63/1.4, UA pending, volume depletion, encourage increased fluids, awaiting U/A." Physician #1 failed to address the resident's sudden change in behavior and weight loss. The record was reviewed September 16, 2008. D. A review of Resident #10's record revealed a speech therapist' s note dated July 25, 2008 at 1330 (1:30 PM):" ...Patient presents with a severe-profound oral-pharyngeal dysphasia ...poor oral control ..." The resident received therapy from the speech language therapist for dysphasia on June 17, 25, 26, 30 and July 1, 2, 4, 5, and 7, 2008. On July 6, 2008 at 2110 (9:10 PM), a nurse's note described a right buttocks pressure sore. According to Physician #1's note dated July 8, 2008,"Patient status, chart/orders reviewed and signed, afebrile, physical exam unremarkable, stable, continue present meds and treatment." Physician #1 failed to address the resident's dysphasia and newly developed pressure sore. On July 16, 2008, the resident received a feeding tube. According to the physician's note dated August 12, 2008,"Patient without distress, chart/orders reviewed and signed, vital signs stable, afebrile, physical exam unchanged, stable, continue present orders and treatment." Physician #1 failed to address the resident' s newly placed feeding tube. The record was reviewed September 16, 2008.	F 386	**24.) 483.35(i) SANITARY CONDITIONS (con't)** 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 develop for noncompliant items. This report will be given to the Administrator monthly. **1A. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 2 and include the falls. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required. **1B. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 4 and include the skin condition and weight loss. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required	10/25/08 11/308 11/3/08 On-going 11/3/08 11/3/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 60 E. A review of Resident #13's record revealed the resident's weight for 2008 as follows: June 135 pounds July 129 pounds August 125.3 pounds Hospice care was initiated August 26, 2008 and continued through the time of this review. According to Physician #1's note dated September 2, 2008,"Patient without distress, chart/orders reviewed and signed, vital signs stable, afebrile, physical exam unchanged, continue present meds and treatment." Physician #1 failed to address the resident's admission into hospice care and weight loss. The record was reviewed September 19, 2008. F. A review of Resident #16's record revealed the following weights for 2008: March 120.2 April 117.8 May 117.8 June 112.4 July 115.8 According to Physician #1's note dated July 10, 2008,"Patient without distress. Chart/orders reviewed and signed, vital signs stable, afebrile, physical exam patient remains asymptomatic with TSH/T4 -0.01/0.88. Continue to monitor for signs and symptoms of Hypothyroidism, continue present meds and treatments." Physician #1 failed to address the resident's weight loss. The record was reviewed September 17, 2008.	F 386	**1C. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 7 and include the change in behavior and weight loss. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required. **1D. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 10 and include the feeding tube. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required .	11/3/08 11/3/08 On-going 11/3/08 11/3/08 On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 61 2. Upon completing the history and physical form for Resident #5's the physician failed to review the total program of care. A review of the Admission and Annual Physical Examination form completed April 9, 2008 lacked evidence that the Advance Directives and Physical Examination sections were completed. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that the H&P form was incomplete. The record was reviewed on September 18, 2008.	F 386	**1E. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 13 and include the admission to hospice and weight loss. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required.	11/3/08 11/3/08 11/3/08 On-going
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. 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 rehabilitation staff delayed service to Resident #10. The findings include: A readmission physician's order dated June 16,	F 406	**1F. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident # 16 and include the weight loss. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required.	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	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 62 2008 directed, "Speech evaluation." The initial evaluation was conducted on June 17, 2008, with additional orders to treat for dysphasia. The treatment began June 25, 2008, seven (7) days after the initial evaluation. A face-to-face interview was conducted with Employee #22 on June 17, 2008 at 5:30 PM. He/she stated, " It's our policy to evaluate and treat within 72 hours of receiving the order. A speech therapist left at the end of May (2008) and another began about two weeks later. The newly hired speech therapist screened the back log of residents first and then started therapy. We just didn't have anyone to do the therapy." The record was reviewed September 17, 2008.	F 406	**2. 483.40(b) PHYSICIAN VISIT** 1.The physicians who failed to meet this requirement will review the total plan of care for resident #5 and the advanced directive and 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required.	11/3/08 11/3/08 11/3/08 On-going
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**483.45(a) SPECIALIZED REHABILITATIVE SERVICES** 1. The resident in question was treated and Discharged from skilled speech and language Services. 2. All Carroll Manor Speech and Language Orders between 5/19/08 and 6/16/08 will be Reviewed and inspected for compliance to Treatment orders. 3. The current system for the receipt of Orders at Carroll Manor will be changed in Order for CM staff to receive orders directly. This topic will also be an agenda item at the 10/31/08 Rehabilitation Services Staff meeting. A Daily "run report" will be inspected in order To identify residents that have Rehabilition Orders. A weekly inspection of the "resulting Report" will be performed in order identify Residents that were treated by CM-Rehab Services. The Director will monitor results Monthly and make corrections as needed. 4. The Director will report monitoring Results and corrective actions to the QI Committee quarterly.	11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) supplemental resident, it was determined that the facility staff failed to document the administration of a controlled substance on the May, June, July and August 2008 Medication Administration Record (MAR) for Resident JH7. The findings include: The April 1 through May 31, 2008 Physician's Order Sheet signed by the physician on April 4, 2008 directed, "Lorazepam 1mg tablet by mouth every 8 hours as needed for severe agitation". The May 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered three (3) times, May 17, 19 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 May 17 (1030 & 1800), 19, 22 and 23 2008. There was no evidence on the May 2008 MAR that the Lorazepam was administered on May 17 (1800) and 23. The June1 through July 31, 2008 Physician's Order Sheet signed by the physician on June 19, 2008 directed, "Lorazepam 1mg tablet by mouth every 8 hours as needed for severe agitation". The June 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered	F 425	**483.60(a),(b) PHARMACY SERVICES** 1.Next dose of Lorazepam administered was signed in MAR for resident # JH7. 1. All residents identified on controlled substances will be reviewed to ensure the documentation on the MARs were complete. 3. Staff will be in serviced on med pass protocol. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	9/18/08 11/308 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 65 There was no evidence on the August 2008 MAR that the Lorazepam was administered on August 3, 2008 and that the Lorazepam was signed as administered on the Controlled Drug Record for August 28, 2008. A face-to-face interview was conducted on September 17, 2008 at approximately 3:55 PM with Employee #3. He/she acknowledged that the MAR and the Controlled Drug Record did not match regarding the administration of Lorazepam. The record was reviewed on September 17, 2008.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 66 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to properly store the medications in accordance to the manufacturer's specifications in two (2) of six (6) units and medications improperly stored in Resident JH2's room. The findings include: 1. Facility staff failed to store medications in accordance with the manufacturer's specifications. According to the facility's "Specialized Long Term Care Nursing Drug Handbook 2008", pages 145 - 146 Calcitonin nasal spray, stipulates, " Fortical: Store unopened bottle under refrigeration 36 degrees Fahrenheit (F) to 46 degrees F. After opening, store for up to 30 days at 68 degrees F to 77 degrees F, ... Store in upright position."; and pages 561-562 Xalantan ophthalmic drops, stipulates, "Store intact bottles under refrigeration 36 degrees F to 46 degrees F." On September 19, 2008 between 11:20 AM and 3:40 PM during the inspection of the medication storage areas, containers of unopened Fortical	F 431	**1.) 483.60(b), (d), (e) PHARMACY SERVICES** 1. The Fortical Nasal Spray, 200 units and the Xalantan eye drops were discarded and replacements were obtained and Stored per manufacturers specifications. 2. Storage specifications on all medications will be adhered to. 3. All licensed staff will be in serviced on proper storage of medication. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meetings. **2.) 483.60(b), (d), (e) PHARMACY SERVICES** 1. Employee # 24 was observed on next Med pass to ensure that medications were not left in residents room unattended. 2. All licensed staff will be observed during Med pass to ensure that medications are not left in room unattended. 3. Staff will be in serviced on the med. pass protocol. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meetings.	9/19/08 11/3/08 11/3/08 10/9/08 9/19/08 11/3/08 11/3/08 10/9/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 67 nasal spray and Xalantan eye drops were observed in the medication carts. 1st Floor (1) Unopened Fortical nasal spray 200 units container (1) Intact Xalantan eye drops 3rd Floor (1) Unopened Fortical nasal spray 200 units container (1) Intact Xalantan eye drops A face-to-face interview conducted at the time of the observations with Employees #3 and #28. They acknowledged that the Fortical nasal spray and Xalantan eye drops were stored improperly. 2. Facility staff left medications at the resident's bedside unattended. On September 16, 2008 at approximately 10:00 AM during the medication pass for Resident JH2, Employee #24 left medication at the resident's bedside and went out of the room from 10:05 AM returning at 10:08 AM to the medication cart to search for pain medication to administer to the resident. The following medications were left at the bedside: Buderprion SR 100mg [1] tablet, Colace 100 mg [1] capsule, Zinc 50 mg [1] capsule, Vitamin C 500 mg [1] tablet, Cyclobenzaprine 10 mg [1] tablet, Oystershell Ca plus Vitamin D 500mg/200mg [1] tablet , Ferrous Sulfate 325 mg tablet [1] tablet, Amlodipine 10 mg [1] tablet, Multivitamin [1] tablet, Meclizine 12.5mg [1] tablet, Spiriva 18 mcg Handihaler [1] capsule,	F 431	**1. 483.65(a) INFECTION CONTROL** 1. The employee was immediately corrected. 2. All employees were instructed not to carry food and cleaning utensil simultaneously. 3. In service was given to all staff regarding infection control and proper food handling. 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 develop for noncompliant items. This report will be given to the Administrator monthly. **2. 483.65(a) INFECTION CONTROL** 1. The mop immediately stored. 2. The entire cook preparation areas were inspected to ensure that cleaning utensils were removed. 3.An in service was given to staff regarding infection control and proper food handling. 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 develop for noncompliant items. This report will be given to the Administrator monthly. **3. 483.65(a) INFECTION CONTROL** 1. Employee was corrected immediately. 2. The entire cook preparation areas were inspected to ensure that cleaning utensils were removed from the area. 3. An in service was given to staff regarding infection control and proper food handling. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/14/08 9/27/08 10/25/08 9/14/08 9/27/08 10/25/08 9/27/08 10/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 68 Cospt eye drops, and Advair 500/50 MDI. A face-to-face interview was conducted at the time of the observation with Employee #24. He/she acknowledged that the medications were improperly stored left unattended.	F 431	**4.) 483.65(a) INFECTION CONTROL** 1. Associates instructed to leave sanitized items in appropriate storage area. 2. This is monitored daily my supervisors. 3. In services given to staff . 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/19/08 10/11/08 10/25/08
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that facility staff failed to prevent infections as evidenced by: in the main kitchen 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, soiled nebulizer machine, oxygen tubing observed on the floor, soiled lift strap for the mechanical lift, and oxygen concentrator filer soiled; and failed to practice aseptic technique while removing the soiled dressings from the resident's room. The findings include:	F 441	**5.) 483.65(a) INFECTION CONTROL** 1. Associated immediately corrected. 2. All associates were given instructions on wearing gloves when transferring food. 3. Inservices were given to staff. 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 develop for noncompliant items. This report will be given to the Administrator monthly. **6.) 483.65(a) INFECTION CONTROL** 1. Employee was immediately corrected. 2. All associates were given instructions on wearing gloves when transferring food. 3. Infection control /food handling in service given. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/19/08 10/11/08 10/25/08 9/14/08. 9/27/08. 10/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 69 The observations were conducted in the main kitchen on September 15, 2008 from 8:30 AM through 11:30 AM, in the presence of Employee #13, who acknowledged the findings at the time of the observations. 1. At 8:40 AM, Employee #20 was observed in the main kitchen carrying two (2) hotel pans of cooked hamburgers in one hand and a floor mop in other. The employee laid the mop against the counter while placing meat on same counter. 2. At 9:30 AM, the floor mop was observed leaning against sink by the cook's preparation area where food was being prepared. 3. At 9:35 AM Employee #19 was observed carrying the floor mop towards the walk-in refrigerator through the area where food was being prepared. 4. Sanitizer towels were sitting open on counter where macaroni and spaghetti were located and across a food preparation area. 5. Employee #20 was observed transferring rice from a cooking to serving vessel without gloves at approximately 10:50 AM. 6. Employee #21 was observed filling dessert dishes with fruit. The employee was observed removing one (1) glove, retrieved a sanitation card from his/her ID holder, handed it to supervisor, and did not wash hands before replacing glove and returned to filling the dessert dishes. The above cited dietary observations were made in the presence of Employee #13 who	F 441	**7. 483.65(a) INFECTION CONTROL** 1. The nebulizer was cleaned. 9/15/08 2..All nebulizers were checked and cleaned as needed. 11/3/08 3. Staff will be in serviced on infection control practices. 11/3/08 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 11/3/08 **8. 483.65(a) INFECTION CONTROL** 1. The tubing was removed. 9/16/08 2..All residents using oxygen tubing were inspected and tubing was removed as needed. 11/3/08 3. Staff will be in serviced on infection control practices. 11/3/08 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 11/3/08 **9.) 483.65(a) INFECTION CONTROL** 1. Mechanical lift strap was sent immediately to laundry for cleaning. 9/15/08 2. All mechanical lift straps were assessed and cleaned as needed. 11/3/08 3. Staff will be in serviced on infection control practices. 11/3/08 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 70 acknowledged the findings at the time of the observations. The following observations were made during the environmental tour conducted on September 15 and 16, 2008 in the presence of Employee #23 who acknowledged the findings at the time of the observations. 7. A nebulizer machine was observed with accumulated debris in room 314 in one (1) of one (1) nebulizer machines observed. 8. Oxygen tubing was observed connected to an oxygen concentrator and on the floor in room 316, in one (1) of one (1) observation of oxygen tubing on the floor. 9. The lift strap for the mechanical lift on the 3rd floor was observed soiled in one (1) of one (1) soiled lift straps observed. 10. The filter to an oxygen concentrator in room 546 was soiled with accumulated dust in one (1) of one (1) soiled oxygen concentrator filter observed. 11. Facility staff failed to practice clean technique while removing the soiled dressings from the resident's room. On September 17, 2008 at approximately 10:30 AM Employee #24 performed a dressing change on the right heel and right lateral foot of Resident P1. During the dressing change, Employee #24 placed the soiled dressings with drainage into a	F 441	**10.) 483.65(a) INFECTION CONTROL** 1. The filter was changed. 9/15/08 2.. All residents on oxygen filters were inspected and changed as needed. 11/3/08 3. Staff will be in serviced on infection control practices. 11/308 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. 11/3/08 **11.) 483.65(a) INFECTION CONTROL** 1. Disposal of infectious material policy was reviewed with employee # 24. 9/17/08 2. Disposal of Infectious Material Policy will be adhered to during dressing changes. 11/3/08 3. Staff will be in serviced on infection control protocol. 11/3/08 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation at quarterly QI meeting. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 71 clear plastic bag in a trash can in the resident ' s room. Upon completion of the dressing change, Employee #24 removed the clear bag (with the soiled dressings) from the trash can and placed it in the biohazardous receptacle in the Soiled Utility Room. A face-to-face interview was conducted with Employee #5 at approximately 11:00 AM on September 17, 2008. He/she stated that the soiled dressings should be placed in a red plastic bag in the resident's room and the red bag should be placed in the biohazardous receptacle in the Soiled Utility Room. A review of the Infection Control (Housekeeping Services) Policy with an effective date of March 11, 1996 and last reviewed on July 31, 2008 revealed the following statements under Procedure: " 2. Disposal of Infectious Material - All infectious or contaminated materials to include, disposable tissue, dressing, paper towels, etc, be bagged before being removed from the resident ' s room for disposal. Such articles should be placed in 'red plastic bag before removing such from the resident's room and disposed of in appropriate receptacles." The policy was reviewed on September 18, 2008.	F 441		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	F 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 72 This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen on September 15, 2008 from 8:40 AM through 11:30 AM, it was determined that facility staff failed to provide trash receptacles for the hand washing sinks. The findings include: Two (2) hand washing sinks were observed in the main kitchen. The designated trash receptacles for the used paper towels required lifting the lid before disposing of the paper towels, thus re-contaminating washed hands. This observation was made in the presence of Employee #13 who acknowledged the findings at the time of the observation.	F 444	**483.65(b)(3) PREVENTING SPREAD OF INFECTION** 1. The trash cans were replaced. 2. All trash cans were checked for appropriate use in the kitchen.. 3. An in-service is scheduled. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	9/14/08 10/27/08. 10/25/08
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations of the main kitchen September 15, 2008 from 8:40 AM through 11:30 AM, it was determined that facility staff failed to maintain safe fire safety as evidenced by propping open fire doors. The findings include: During the tour of the main kitchen, it was observed that the door to the outside corridor by	F 454	**483.70 PHYSICAL ENVIRONMENT** 1.Doors were immediately closed. 2. All doors checked. 3. Staff was instructed not to prop open doors with cans. 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 develop for noncompliant items. This report will be given to the Administrator monthly.	10/8/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 454	Continued From page 73 walk-in refrigerator propped open with two (2) large cans. The door to the dry storage area was propped open with two (2) large cans. Both doors were identified by Employee #13 as fire doors. These observations were made in the presence of Employee #13 who acknowledged the findings at the time of the operations.	F 454		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for nine (9) of 30 sampled residents, it was determined that facility staff failed to: document allergies on the Physician Order Sheet (POS) for one (1) resident, consistently document one (1) resident's code status and diet consistency, clarify one (1) resident's diagnosis, consistently describe reddened skin for one (1) resident, consistently document the use of pain medication and its effectiveness, explanation of withholding blood pressure medication and follow up on loose stool for one (1) resident, accurately transcribe a tube feeding product order for one (1) resident, document when a dressing change was	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 74 conducted for one (1) resident, consistently document code status for one (1) resident and transcribe an order for catheterization for one (1) resident. Residents #1, 2, 3, 4, 5, 8,10, 22 and 28. The findings include: 1. Facility staff failed to document allergies on the Physician Order Sheet (POS) for resident #1. A review of the Medical revealed that Resident #1 had an allergy to Penicillin (PCN) on the front sheet in chart. The facility admission assessment on June 21, 2008 indicated the resident was allergic to PCN and ASA (Aspirin). The history and physical indicated the resident was allergic to PCN. The Physicians Order Sheet (POS) Dated and signed August 5, 2008 indicated that the resident has NKDA [no known drug allergies]. A face to face interview was conducted with Employee #5 at approximately 4:00 PM on September 18, 2008. He/she acknowledged that the Physicians Order Sheet indicated nkda [no known drug allergies] and that the clinical record lacked consistent documentation of allergies for Resident #1. 2. Failed to document the current code status on the History and Physical [H&P] form for Resident #2. A review of a telephone order dated February 12, 2008 directed, "1. Clarification of Code status. 2. D/c [discontinue] DNR 3. Pt [patient] is Full Code." A review of the Admission and Annual Physical	F 514	**1.) 483.75(l)(1) CLINICAL RECORDS** 1. All allergies were identified on POS for Resident # 1. 9/18/08 2. All resident records will be reviewed to ensure all allergies are identified and care planned. 11/3/08 3. Staff will be in serviced on importance of documenting all allergies on physician order sheet. 11/3/08 4. Care plan audit on allergies will be done by Nurse Manager or designee, submitted to Director of Nursing for presenting at quarterly QI meeting. 11/3/08 **2.) 483.75(l)(1) CLINICAL RECORDS** 1.The physicians who failed to meet this requirement will review the total plan of care for resident #2 and include the current advanced directive on the history. 11/3/08 2.The physicians will review all of their resident's plans of care to insure compliance with this requirement. 11/3/08 3.The Medical Director will educate all attending physicians on their responsibility to review the total plan of care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance monthly reported will be prepared for Medical Director. 11/3/08 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 75 Exam form completed May 5, 2008 revealed, "... Advance Directives: DNR ..." The record lacked evidence that the physician document the current code status when completing Resident #2's H&P. A face-to-face interview was conducted on September 16, 2008 at 2:40 PM with Employee #4. He/she acknowledged that Resident #2 was a "Full Code" and that the physician did not document the current code status on the H&P. The record was reviewed on September 16, 2008. B. Facility staff failed to accurately document the current meal consistency on the "Safe Swallow Guide and tray ticket" for Resident #2. A review of the Physician Order sheets for August 1, 2008 through September 30, 2008 and signed by the physician on August 12, 2008 directed, "Diet: Pureed Diet ..." A review of the "Safe Swallow Guide" last updated July 21, 2008 revealed"... Meal consistencies: Food-regular ..." A review of the September 16, 2008 lunch tray ticket documented "Regular [indicating the type of diet]." On September 16, 2008 Resident #2 was observed having lunch and consuming a pureed meal as per the physicians order. The "Safe Swallow Guide" and the lunch tray ticket meal lacked evidence that they were accurately updated to correspond with the	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 76 physicians order. A face-to-face interview was conducted on September 16, 2008 at 2:40 PM with Employee #4. He/she acknowledged that" A Safe Swallow Guide" and the lunch tray ticket did not reflect the current physician's order. The record was reviewed on September 16, 2008. 3. Facility staff failed to clarify a diagnosis of Diabetes Mellitus listed on the"Inter-Agency Referral Transfer Form" for Resident # 3. A "Inter-Agency Referral Transfer Form" dated July 10, 2008 included a diagnosis of Diabetes Mellitus. Further review of the Physician's Order Sheet signed and dated July 24, 2008 and the quarterly Minimum Data Set (MDS) completed July 24, 2008 failed to reveal a diagnosis of Diabetes Mellitus. A face-to-face interview was conducted with Employee #5 at approximately 3:15 PM on September 15, 2008. He/she acknowledged that the resident did not have a diagnosis of Diabetes Mellitus and added " We did not follow this (the referral form) because it was written by the nurse." The record was reviewed on September 15, 2008. 4. Facility staff failed to accurately document the resolution of an area of reddened skin for Resident #4. Review of Resident #4's record revealed the following nurses' notes: May 19, 2008 at 9:15 AM: "A darkened area was	F 514	**3.) 483.75(l)(1) CLINICAL RECORDS** 1. Physician reviewed resident # 3 record and determined that Resident #3 was not a Diabetic. Finger sticks were being done because of steroids therapy in hospital. 2.. All other residents will be checked to ensure diagnosis is correct. 3. All staff will be in serviced on review of "Inter-Agency Referral Transfer Form" and clarify all discrepancies. 4. Nurse Manager will conduct monthly audits on diagnosis update and submit to Director of Nursing for presentation at quarterly QI meeting. **4.) 483.75(l)(1) CLINICAL RECORDS** 1. Documentation was placed in Resident # 4 chart indicating resolution of reddened area. 2. All other residents must be checked to correct documentation. 3. In-service will be done on staff regarding follow up documentation. 4. Weekly skin sheets will be completed, reviewed by wound nurse and submitted to Director of Nursing for presentation at quarterly QI meeting.	11/3/08 11/3/08 11/3/08 11/3/08 9/16/08 11/3/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 77 observed to right buttock and Proshield Plus was applied..." May 27, 2008 at 1100 (11:00 AM): "Reddened area with a dry scab noted over the Right gluteus area ..." There was no further entry regarding the above skin area. A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:45 PM. He/she acknowledged that the above identified skin area was not tracked through healing and resolution of the area. 5. Facility staff failed to document a follow up assessment when Resident #5 had loose stools, low blood pressures and consistently document the pain level and the effectiveness of pain medication when it was administered. A. Facility staff failed to document a follow up assessment when Resident #5 had loose stools. An IDT [interdisciplinary team] note dated September 3, 2008 at 2200 ... revealed "Resident was observed with loose stools times three (3). Stomach assessed soft and firm. Stools very offensive in odor ...MD [medical doctor] advised to continue to monitor and encourage PO [by mouth] fluids. If stools persist till next day, to call back. Resident condition stable. Drank whole bottle of ensure and orange/pineapple juice 120 cc. No apparent distress noted." A further review of the record lacked evidence that a follow up assessment was conducted until September 10, 2008 at 0500 when the resident	F 514	**5A.) 483.75(l)(1) CLINICAL RECORDS** 1. Resident # 5 was assessed and there was no episode of loose stools. 9/16/08 2. Follow up documentation will be done on residents with change in condition. 11/3/08 3. In-service will be done on staff regarding importance of follow up documentation. 11/3/08 4. Nurse Manager or designee will review 24 hour report daily to ensure that all acute changes are followed up. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 78 had additional loose stools. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that there was no follow up documentation after the resident was observed to have loose stools. The record was reviewed on September 18, 2008. B. Facility staff failed to document a follow up assessment when Resident #5 had low blood pressures. A review of the July 2008 MAR revealed a physician's order that directed the following: Cozaar 100 mg tablet Losart potassium one (1) tablet by mouth daily for hypertension (hold if SBP [systolic blood pressure] less than 120 DBP [diastolic blood pressure] less than 60). A review of the July 2008 MAR [medication administration record] revealed that on July 19, 21, 23, 26, 27, and 29, 2008 Resident #5 had a low blood pressure and his/her medication was withheld in accordance with the physicians order. The IDT [interdisciplinary team] notes lacked evidence that after the resident's blood pressure reading was documented as low, there were further documented assessments or follow up regarding Resident #5's blood pressure. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that there was no follow up documentation after the resident was observed to have low blood pressures. The record was reviewed on September 18, 2008.	F 514	**5B.) 483.75(l)(1) CLINICAL RECORDS** 1. Resident # 5 medications were adjusted. 9/18/08 2. Follow up documentation will be done on residents with change in condition. 11/3/08 3. In-service will be done on staff regarding the importance of follow up assessment and documentation. 11/3/08 4. Nurse Manager or designee will review 24 hour report daily to ensure that all acute changes are reassessed and follow up documentation is done. 11/3/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 79 C. Facility staff failed to consistently document the pain level and effectiveness of pain medication when administered for Resident #5. A review of the March 2008 MAR [medication administration record] revealed that Oxycodone w/APAP 5/500 Cap ... for minor pain was administered on March 14, 28, 29, and 31, 2008. Tylox Oxycodone w/APAP was administered for moderate-severe pain on March 12, 13, 14,16, 17, 23, 25, 26, 30, and 31, 2008. A review of the "Vitals Report" revealed that on March 13, 14, 17, 18, 22, 23, 24, 27, 28, 29, 30, and 31, 2008 pain level(s) were assessed for Resident #5. According to the "As needed" Administrations Report, Resident #5's pain effectiveness was assessed on March 13, 14, 16, 17, 23, 25, 26, 28, 29, 30 and 31, 2008. The record lacked evidence that when pain medications were administered, an assessment of the resident's pain level and/or a follow up assessment was not consistently conducted to determine if the pain medication administered was effective. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that pain assessments and/or effectiveness of the medication were not consistently documented on Resident #5's record. The record was reviewed on September 18, 2008. 6: Facility staff failed to document on the Medication Administration Record [MAR] when a	F 514	**5C.) 483.75(l)(1) CLINICAL RECORDS** 1. Resident # 5 was assessed for pain and medicated as needed with follow up assessment and documentation. 2. All licensed staff will be observed during med pass to ensure consistent documentation of administered as needed medication. 3. Staff will be in serviced on med pass protocol for as needed medications. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	9/18/08 11/3/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	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 dressing changed yesterday September 14, 2008 due to resident receiving his/her shower dressing change every 3 days. Right toe area dressing changed 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 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 completed. A face-to-face interview 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). A physician's telephone order dated July 17, 2008	F 514	**6.) 483.75(l)(1) CLINICAL RECORDS** 1. Next treatment done on resident # 8 was signed on MAR. 2. All licensed staff will be observed during treatment competencies to ensure documentation of treatment done. 3. Staff will be in serviced on wound competency protocol. 4. Monthly treatment competencies will be randomly done by wound care nurse and submitted to Director of Nursing for presentation at quarterly QI meeting.	9/15/08 11/3/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 81 and signed by the physician the same day, directed, "Osmolite 1.2 via G-tube every 4 hours ..." A review of Resident #10's record revealed a POS dated August 12, 2008,"Osmolite 1 can every 4 hours from 0600 - 2400." According to the manufacturer, Osmolite is produced as follows per can: Osmolite 1 calorie, Osmolite 1.2 calorie, and Osmolite 1.5 calorie. A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 10:00 AM. He/she acknowledged that the correct strength of Osmolite was not documented on the August 12, 2008 POS. The record was reviewed September 16, 2008. 8. Facility staff failed to document the current code status on the History and Physical [H&P] form for Resident #22. A review of the Admission and Annual Physical Exam form completed August 12, 2008 revealed, " ... Advance Directives: Full Code ..." A review of the Do Not Attempt Resuscitation/Advance Directive, last updated January 25, 2008 revealed, " ...DNR ..." A review of review of the physician order form for September 1, 2008 through October 31, 2008 and signed by the physician on August 29, 2008 revealed, " ...Advance Directives: DNR ..." The record lacked evidence that the physician documented the current code status when completing Resident #22's H&P.	F 514	**7.) 483.75(l)(1) CLINICAL RECORDS** 1. Physician order sheet for resident # 10 was reviewed, and reflects current tube feeding orders. 2. All residents with tube feeding will receive the specified formula. 3. Staff will be in serviced on importance of documenting the specified formula of tube feeding ordered by physician. 4. Nurse Manager or designee will review tube feeding orders monthly. **8.) 483.75(l)(1) CLINICAL RECORDS** 1.The physicians who failed to meet this requirement will review the total plan of care for resident #22 and include the current advanced directive on the history. 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 attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required.	9/16/08 11/3/08 11/3/08 11/3/08 11/3/08 11/3/08 11/3/08 11/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	09/19/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 82 A face-to-face interview was conducted on September 19, 2008 at 9:50 AM with Employee #5. He/she acknowledged that H&P did not document the current code status. The record was reviewed on September 19, 2008. 9. Facility staff failed to correctly transcribe an order for In/out catheterization for Resident #28. A review of the medical record reveals an interim physician order dated July 24, 2008 for "intermittent catheterization PRN and daily every hs ..." A review of the Physicians Order Sheet dated and signed August 5, 2008 indicated an "as needed" order dated July 21, 2008 "Intermittent catheterization PRN at Hs daily for sensation of inability to void." A review of the interdisciplinary notes from July 21, 2008 until present lacked documentation that the resident received an In/out cath every HS [hour of sleep]. Facility staff was unable to provide documentation of Input and Output records for this resident at time of survey. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed. The record was reviewed September 17, 2008.	F 514	**9.) 483.75(l)(1) CLINICAL RECORDS** 1. Routine order for intermittent catherization PRN and daily every HS written July 24, 2008 was discontinued for Resident # 28. 2. Residents orders will be transcribed as written by physician. 3. Staff will be in serviced on importance of transcribing physician orders correctly. 4. Nurse Manager or designee will review new orders for correct transcription.	9/18/08 11/3/08 11/3/08 11/3/08

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095034	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/19/2008
NAME OF PROVIDER OR SUPPLIER **CARROLL MANOR NURSING & REHAB**	STREET ADDRESS, CITY, STATE, ZIP CODE **725 BUCHANAN ST., NE WASHINGTON, DC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 274	483.20(b)(2)(ii) RESIDENT ASSESSMENT- WHEN REQUIRED

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary 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 days - The resident was coded as continent for bowel and bladder function.

Section M - Skin Condition - The resident's skin was intact.

The resident was hospitalized from July 2 through 10, 2008. A quarterly MDS assessment was completed on July 24, 2008, with an Assessment Reference Date of July 17, 2008.

Section G - The resident was coded as requiring extensive assistance for toileting, dressing and bathing.

Section H - The resident was coded as being occasionally incontinent.

Section K - Oral/Nutritional Status - The 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 Procedures - The resident was coded for requiring monitoring an acute medical condition.

According to the "MDS 2.0 User's Manual", page 2-7,

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095034	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/19/2008

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

ID PREFIX TAG	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.