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 _____	09/19/2011

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

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) was conducted on September 12 through 19, 2011. The deficiencies are based on observation, record review and resident and staff interview for 39 sampled residents. An Immediate Jeopardy (IJ) at CFR 483.70 (c) (2) "Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition" was identified on September 13, 2011 at 5:54 PM. The allegation of removal of the Immediate Jeopardy situation was received and verified on September 14, 2011 at 3:00 PM and the Immediate Jeopardy was lifted at that time.	F 000	**Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This Plan of Correction (POC) is prepared and/or executed because it is required by the state and federal laws.**	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family and staff interviews, for one (1) of 39 sampled residents, it was determined that the facility failed to promptly resolve a grievance for Resident #291. The findings include: 1. During an interview with Resident #291 on September 13, 2011 at 11:05 AM, it was revealed that one (1) pair of pants and six (6)	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Sanchi	Administrator	11/2/2011

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

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F 166	Continued From page 1 pairs of socks had been missing for approximately 3-4 months. A telephone interview was conducted on September 16, 2011 at 10:35 AM with Resident #291's [responsible party]. He/she stated, " It was a couple pairs of socks, not five (5) pairs, and two (2) pairs pants. One (1) pair was a blue khaki and the other was blue sweats [pants]. They are still missing and I have to admit sometimes I find [Resident #291's] clothes in Resident #212's hamper. I did tell Employee #23 about the missing items. I can't remember what she/he told me. When I ask him/her things, he/she usually gives me good directions where to go. " A face-to-face interview was conducted with Employees #7 and #23 on September 16, 2011 at approximately 10:30 AM regarding Resident #291 ' s missing items. Employee #7 replied, " I did not know about this. " When Employee #23 was queried, he/she replied, " I do recall the [responsible party] telling me something about missing items, but I told him/her to tell the nurse. I always tell family members this, when things are missing ...I direct them to the nurse. " A review of Resident #291 ' s clinical record revealed, " Clothing List " sheet dated December 27, 2010 [admission date]. Under Clothing , " Three (3) long sleeve shirts, five (5) T-Shirts, five (5) prs [pairs] underwear, five (5) prs socks, one (1) pullover sweater, one (1) Belt, one (1) pair of pants, two (2) pajamas bottom, one (1) pajamas top. Miscellaneous: one (1) pair house shoes, one (1) pair of black dress shoes, one (1) pair of gloves " Under miscellaneous,	F 166	**F 166- 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** **1-** 1. Resident # 291 and responsible party were interviewed for missing items as according to policy 1518-Report of Concern. Resident and responsible party will be notified of the findings.	10/26/11
			2. All residents will be interviewed for grievances and all grievances will be addressed in a timely manner.	11/3/11
			3. All staff will be in-serviced on the revised Report of Concern policy.	11/3/11
			4. Nurse Manager or designee will review complaint log daily to ensure all identified complaints have been addressed and resolved. Monthly monitoring will be done by QI Director to ensure compliance and results will be presented at the quarterly QA/QI meeting.	On-going

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F 166	Continued From page 2 dated June 8, 2011 "two (2) pair pants. " The facility' s policy " Report of Concern, Policy No.: 1518 " items #1 and #2 under Procedure read as follows: #1 The Report of Concern forms are maintained at all nurses ' stations. #2. Staff will report all residents 'complaints to supervisors and supervisors will seek to resolve complaints immediately. Complete Report of Concern form." A review of the grievance/complaint log book lacked evidence of any concerns conveyed by Resident #291 since January 20, 2011. Facility staff failed to identify, act on and resolve a grievance voiced by Resident #291 and his/her responsible party. There was no evidence that facility staff acted in a timely manner to address concerns regarding missing clothing items. The findings were reviewed and confirmed by Employee #7 on September 16, 2011. 2. Facility staff failed to report and follow up on concerns verbalized by there responsible party of resident #291 as it pertains to staff interactions. A telephone interview was conducted with the responsible party of Resident #291 on September 19, 2011 at approximately 10:35 AM. During the interview the responsible party stated he/she had met with Employee #7 regarding a negative dialogue that occurred with Employee #20. In addition the responsible party further stated a request was made to remove Employee #20 from providing care to Resident #291." A review of the facility's "Grievance and Complaint Log" book revealed no documented	F 166	**F 166- 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** **2-** 1. Investigation was initiated for concerns verbalized by responsible party of resident # 291. 2. All residents will be interviewed. All concerns verbalized by residents and residents responsible parties will be reported to the appropriate party and investigated. 3. All staff will be in-serviced on the Report of Concern policy. 4. Nurse Manager or designee will review complaint log daily to ensure all identified complaints have been addressed and resolved. Monthly monitoring will be done by QI Director to ensure compliance and results will be presented at the quarterly QA/QI meeting.	10/26/11 11/3/11 11/3/11 On-going

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F 166	Continued From page 3 grievance and/or complaint for Resident #291. The facility ' s policy " Report of Concern " items #1 and #2 under Procedure read as follows: #1 The Report of Concern forms are maintained at all nurses' stations. #2. Staff will report all residents 'complaints to supervisors and supervisors will seek to resolve complaints immediately. (Complete Report of Concern form.). " Facility staff failed to act on care concerns expressed by Resident #291 ' s responsible party.	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observations and interviews for four (4) of five (5) dining observations, it was determined that facility staff failed to promote dignity during dining as evidenced by: no interventions for one (1) resident eating rapidly; one (1) resident repeatedly placing an empty soda can to his/her mouth; one (1) resident dining at a table with soiled table linen; one (1) resident who was assisted with dining as staff stood and four (4) residents that sat idle as others dined. Residents ' #7, #12, #93, #119 and #136.	F 241		

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F 241	Continued From page 4 The findings include: First Floor Dining Observations: The following observations were made during dining observations of the 1st floor dining room on September 12, 2011 between 12:15 - 1:30 PM. A. Resident #7 was observed for more than 30 minutes repeatedly placing an empty soda can to his/her mouth. The resident was not redirected by a staff member and was not encouraged to eat his/her meal. B. Resident # 136 was observed eating at a rapid pace with a spoon. The resident was observed scooping food onto his/her spoon then mixing it with drinks which included water, juice and a nutritional supplement. The resident then used the tablecloth and the arm of his/her shirt to wipe his/her mouth. Resident #136 also ate food that had spilled on the table with his/her hands. Staff did not intervene and did not provide assistance to the resident throughout his/her meal. C. Facility staff failed to ensure that residents dined with dignity as evidenced by one resident observed with soiled table linen that was not changed prior to the lunch meal service. A staff proceeded to fed the resident in the presence of the soiled table linen. Facility staff placed a plate of food on a stained/soiled table linen in front of Resident #119. The CNA fed the resident his/her entire	F 241	**F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY** **1A- First Floor Dining Observations** 1. Resident was redirected at next meal time and encouraged to consume his/her food. 2. All residents observed with distracting behavioral manifestations will be redirected and encouraged to consume meals at meal time. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting. **1B- First Floor Dining Observations** 1. Resident was redirected at next meal time and encouraged to eat at a slower pace and staff provided assistance as needed. 2. All residents that require assistance during meals will be assisted and staff will intervene as needed. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going 9/12/11 11/3/11 11/3/11 On-going

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F 241	Continued From page 5 meal while the stained/soiled table linen was in place. A face-to-face interview was conducted with Employee #16 on September 12, 2011 at 1:20 PM. He/she acknowledged the findings at the time of the observation. Second Floor Dining Observations Facility staff failed to maintain/enhance one resident ' s dignity by standing over Resident #93 while feeding him/her the lunch meal at approximately 11:45 AM on September 15, 2011. A face-to-face interview was conducted with Employee #35 at approximately 11:00AM on September 15, 2011. During the interview the employee acknowledged standing while feeding the resident. The employee added, " Because of the position of the table it was difficult for me to put a chair in the space. I do not usually stand to feed the residents. I always sit. " Third Floor Dining Observations During a dining observation of the lunch meal on September 12, 2011 at 12:15PM, it was determined that facility staff failed to promote Residents dignity and respect by allowing the residents to sit idle while others dined in three (3) of four (4) residents observed. The third floor staff was observed passing out trays. Staff seated four (4) residents at one (1) table. One resident was served and eating while three (3) other residents at the table waited 20	F 241	**1C- First Floor Dining Observations** 1. Linen was changed at the next meal time. 2. All staff will ensure that linen is clean prior to feeding. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting. **2- Second Floor Dining Observations** 1. Resident #93 was fed while employee was sitting at the next meal time. 2. All residents will be fed while employees are seated. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going 9/15/11 11/3/11 11/3/11 On-going

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F 241	Continued From page 6 minutes to get their lunch meal. Fourth Floor Dining Observations During dining observations of the lunch meal on September 12, 2011 at 12:36 PM, it was determined that facility staff failed to promote Resident #12's dignity by allowing the resident to sit idle while others dined. Residents #12 and #36 shared a table in the dining room on the fourth floor. Resident #12 was served at 12:15 PM and proceeded to dine. Resident #36, who required total assistance with meal consumption received his/her meal at 12:36 PM. Resident #36 sat idle greater than 20 minutes while others dined in his/her presence. The findings were discussed during an interview with Employees #2 and #3 on September 13, 2011.	F 241	**3- Third Floor Dining Observations** 1. Resident's at the same table were served at the same time during the next meal time. 2. All residents sitting at the same table will be served at the same time. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting. **4- Fourth Floor Dining Observations** 1. Resident # 36 was provided total assistance with meal so she did not sit idle while others dined during the next meal. 2. All residents sitting at the same table will dine at the same time. 3. All staff will be in-serviced on promoting dignity during the dining experience. 4. Random audits will be conducted by the Nurse Manager or designee on dining observations. Findings will be submitted to Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going 9/12/11 11/3/11 11/3/11 On-going
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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	F 279		

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F 279	Continued From page 7 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, staff interview and observations it was determined that facility staff failed to develop a care plan with goals and approaches consistent with the PASRR [Pre-Admission Screen/Resident Review] Level II Screen for Mental Retardation for Resident #61. The findings include: A medical record review was conducted on September 15, 2011 at 11:48 AM. The face sheet indicated that the resident was admitted December 20, 2002. The PASRR Level II Screen for Mental Retardation dated April 24, 2003 revealed Resident #61 was assessed with Mental Retardation. The screen stipulated that the resident "...could benefit from active treatment as offered in a day program or pre-vocational setting. [S/he] may also benefit from a residential placement in a home like environment, which is handicapped accessible ..."	F 279	**F 279- 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** 1. Resident #61 care plan has been updated to reflect the requirements of the PASRR Level II Screen 2. All residents with a PASRR Level II screen will have their care plans reviewed and updated as needed. 3. In-services will be conducted for all Social Services staff related to updating care plans to reflect the PASRR Level II recommendations. 4. The Social Services Manager or designee will audit the care plans for all residents with PASSR Level II screens monthly and report the findings quarterly to the QA//QI meeting.	9/19/11 11/3/11 11/3/11 On-going

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F 279	Continued From page 8 A review of the comprehensive care plan most recently updated July 12, 2011 lacked evidence that the interdisciplinary team developed goals and approaches consistent with specialized rehabilitative [rehab] services such as those specified in the Level II PASRR screen. There was no evidence that the IDT acknowledged, accommodated and/or decided against the Level II screen findings. A review of Social Service notes and Activity notes lacked evidence of documentation related to specialized rehab services and/or activities consistent with the PASRR Level II Screen. A face-to-face interview was conducted with Employee #5, after review of the care plan he/she acknowledged the findings. The facility staff failed to develop a care plan with appropriate goals and approaches consistent with the PASRR Level II Screen for Mental Retardation for Resident #61. The record was reviewed on September 15, 2011.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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F 280	Continued From page 9 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review it and staff interview for three (3) of three (3) sampled residents, it was determined that facility staff failed to amend the falls care plan with appropriate goals and approaches after three (3) residents that sustained a fall. Residents #92, #237 and #409. The findings include: 1. Facility staff failed to update the fall risk care plan for Resident #92. A review of the clinical record for Resident #92 revealed that the resident sustained a fall without injury on September 9, 2011 while in the dayroom unsupervised. According to the quarterly Minimum Data Set	F 280	**F 280- 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **1-** 1. Resident # 92's fall risk care plan was updated to include appropriate goals and approaches. 2. All residents care plans will be reviewed and updated after a fall. 3. All licensed staff will be in-serviced on reviewing and updating careplans after a fall. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	10/26/11 11/3/11 11/3/11 On-going

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F 280	Continued From page 10 (MDS) dated August 7, 2011, Resident #92 was coded as extensive assistance with a two (2) person support for " Transfers " under Section G 0110 [Functional Status]; and was coded as not steady, only able to stabilize with human assistance in " Moving from Seated to Standing Position " in Section G 0300 [Balance During Transitions and Walking]. The Nursing Progress note dated September 9, 2011 at 9:18 PM read, "Resident was observed lying on the floor on [his/her] right side-no injuries noted-vitals ok - on-call MD called and waiting for return call". A review of the comprehensive care plan dated August 16, 2011 included the problem " At risk for falls due to unawareness of safety parameters, memory deficits " . Observations of the resident ' s room on September 16, 2011 lacked evidence of a bed alarm. There was no evidence that the " At risk for falls due to unawareness of safety parameters, memory deficits " care plan was updated after Resident #92 sustained a fall on September 9, 2011. A face-to-face interview was conducted with Employee #4 on September 16, 2011. He/she acknowledged that Resident #92 that the care plan was not updated. The record was reviewed on September 16, 2011.	F 280		

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F 280	Continued From page 11 2. Facility staff failed to amend the comprehensive care plan of Resident #237 with appropriate goals and approaches after multiple falls. A review of the comprehensive care plan for Resident #237 updated August 16, 2011 revealed the disciplinary team identified "history of falls" as a problem. The approaches developed to address the resident's fall history lacked evidence of interventions and approaches related to the implementation of the custom wheel chair with adaptive seating that was implemented in March 2011. According to physical therapy notes dated July 7, 2011 the chair was implemented to address the resident's postural concerns as Resident #237 was assessed with poor/fair trunk control and posterior pelvic tilt. A face-to-face interview was conducted with Employee # 4. He/she indicated that the residents comprehensive care plan was amended using the "Fall Risk Indicator Tool". A review of the "Fall Risk Indicator Tool" for dates July 6, 2011 and September 7, 2011 revealed the falls were identified for the above dates, however the tool lacked evidence of modifications of the goals and approaches to further ensure safety from falling and lacked evidence that included the implementation of the custom wheel chair with adaptive seating that was implemented in March 2011. Facility staff failed to amend Resident #237	F 280	**F 280- 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **2-** 1. Resident # 237's fall care plan was reviewed and amended to include implementation of a custom wheel chair. 2. All residents fall care plans will be reviewed and amended to include recommended new approaches. 3. All licensed staff will be in-serviced on reviewing and updating care plans after a fall. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/16/11 11/3/11 11/3/11 On-going

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	095034	A. BUILDING _____ B. WING _____	09/19/2011

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F 280	Continued From page 12 comprehensive care plan to include the implementation of the custom wheel chair with adaptive seating that was implemented in March 2011. The record was reviewed on September 16, 2011. 3. Facility staff failed to update the " Falls " care plan after Resident #409 sustained a fall with injury. A review of the incident report dated September 4, 2011 revealed, " Resident sitting up in locked wheelchair in front of nurses station, alert and oriented to person and place, disoriented to time, found on floor at 2050, noted swelling 3 cm x 2.5 cm on left side of head. Resident states my head hurts. " A review of the nursing revealed the following: "September 5, 2011 at 05:24 ...Nurse Input: ... Resident sitting up in locked wheel chair in front of nurse ' s station, found on floor at 2050 on September 4, 2011. Noted swelling left side of forehead, 3 cm x 2.5 cm states, my head hurts ... [Physician] called order to transfer to emergency room ... " "September 5, 2011 at 07:55 resident returned from emergency room at 0640, via stretcher ...neuro [neurological] checks restarted. " A review of the " Falls " care plan initiated August 22, 2011 lacked evidence that the care plan was amended after the fall with goals and/or	F 280	**F 280- 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **3-** 1. Resident # 409 was discharged from the facility at the time of this survey. 2. All residents fall risk care plans will be reviewed and updated after a fall. 3. All licensed staff will be in-serviced on reviewing and updating care plans after a fall. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/7/11 11/3/11 11/3/11 On-going

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F 280	Continued From page 13 approaches to address the residents fall with injury. A face-to-face interview was conducted on September 16, 2011 at 11:00 AM with Employee #8. He/she acknowledged that the care plan was not updated/amended with goals and approaches to address Resident #409 ' s fall with injury. The record was reviewed on September 16, 2011.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on an observations, record review and interviews for one (1) of five (5) dining observations [lunch meal] and one (1) of 38 sampled residents, it was determined that facility staff failed to provide postural positioning to facilitate safe meal consumption for Resident #90 and facility staff failed to follow the physicians order to implement a bed alarm for Resident #92. The findings include:	F 309		

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F 309	Continued From page 14 1. Facility staff failed to provide postural positioning to facilitate safe meal consumption foir Resident #90. An observation of the lunch meal on September 12, 2011 at approximately 12:30 PM revealed Resident #90 was assisted with lunch consumption by Employee #24. The resident was seated in a wheelchair at the dining table and observed leaning to the left side with his/her head tilted downward. A document with instructions for feeding Resident #90 was observed on the table proximal to where the resident was seated. The document was entitled "Safe Swallow Guide " and stipulated, " due to the patients ' swallowing difficulties, these instructions should be followed while he/she is eating and drinking. This temporary plan will help facilitate and improve swallow pattern and minimize the chance of food and liquid falling into the airway and lungs ...seating should be upright and midline positioned with pillows; patient has tendency to lean to left side ..." There was no evidence that pillows were utilized to aid in properly positioning the resident. Facility staff failed to follow the resident's safe swallow guide and provide postural positioning to facilitate safe meal consumption. A face-to-face interview was conducted with Employees #24 and #29 at the time of the observation who acknowledged the failure to utilize pillows for positioning the resident.	F 309	**F 309- 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **1-** 1. Resident # 90 was provided postural positioning to facilitate safe meal consumption for the next meal. 2. All residents who require postural positioning will be positioned appropriately to facilitate safe meal consumption. 3. All staff will be in-serviced on providing postural positioning to facilitate safe meal consumption. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going

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F 309	Continued From page 15 2. Facility staff failed to follow the physicians order to implement a bed alarm for Resident #92. The Physician's Orders for August/September 2011, signed by the physician's on August 2, 2011 directed, "Bed Alarm for safety precautions, when in bed every shift..." Observations of the resident's room on September 16, 2011 lacked evidence of a bed alarm. A review of the comprehensive care plan dated August 16, 2011 included the problem " At risk for falls due to unawareness of safety parameters, memory deficits " . Interventions included the use of a bed alarm for safety precautions. A face-to-face interview was conducted with Employee #4 on September 16, 2011. He/she acknowledged that Resident #92 did not have a bed alarm. Through observation and staff interview, there was no evidence that the facility staff implemented the physician's order for use of a bed alarm as directed. The record was reviewed on September 16, 2011.	F 309	**F 309- 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **2-** 1. Physician order for bed alarm was implemented for Resident # 92. 2. All residents with physician's orders for bed alarms will be reviewed and implemented as appropriate. 3. All licensed staff will be in-serviced on following physician's orders for bed alarms. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/30/11 11/3/11 11/3/11 On-going
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 16 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 record reviews and interviews for one (1) of one (1) sampled residents, it was determined that the facility failed to ensure that Resident #92 received adequate supervision and assistive devices to prevent accidents. The findings include: A review of the clinical record for Resident #92 revealed that the resident sustained a fall without injuries on September 9, 2011 while in the dayroom unsupervised. According to the quarterly Minimum data set (MDS) dated August 7, 2011, Resident #92 was coded as needing limited to extensive assistance in Section G, functional status, activities of daily living. Nursing progress notes dated September 9, 2011 at 9:18 PM read, "Resident was observed lying on the floor on [his/her] right side-no injuries noted-vitals ok - on-call MD called and waiting for return call". Further investigation revealed that the resident was in the dayroom when he/she sustained the	F 323	**F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **1-** 1. Resident # 92 was adequately supervised and assistive device was provided to prevent accidents. 2. All residents will be adequately supervised while in the dayroom and assistive devices will be provided to prevent accidents. 3. All staff will be in-serviced on the process for monitoring residents while in the dayroom. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/9/11 11/3/11 11/3/11 On-going

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F 323	Continued From page 17 fall. Through interview with Employee # 27 on September 16, 2011 at 4:07 PM, it was determined that the fall occurred between 6:00 and 7:00 PM on September 9, 2011 and no staff member was present in the dayroom at the time the accident occurred. A review of the dayroom monitoring schedule for September 9, 2011 revealed that between 6:00 PM and 7:00 PM there is no designated staff member(s) to supervise the dayroom. A review of the comprehensive care plan dated August 16, 2011 included the problem " at risk for falls due to unawareness of safety parameters, memory deficits " . Interventions included the use of a bed alarm for safety precautions, ordered by the physician on May 28, 2010. Observations of the resident ' s room on September 16, 2011 lacked evidence of a bed alarm. A face-to-face interview was conducted with Employee #4 on September 16, 2011; He/she acknowledged that Resident #92 did not have a bed/chair alarm. There was no evidence that the facility implemented measures to adequately supervise Resident #92 as to prevent accidents. The resident was cognitively impaired; dependent for ADL ' s and was at risk for falls. He/she occupied the dayroom on September 9, 2011 without any staff supervision. The record was reviewed on September 16, 2011.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 18 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the main kitchen on September 12, 2011, it was determined that the facility failed to store food under sanitary conditions as evidenced by the ice machine scoop that was stored in a holder half-full of cloudy water and a torn candy wrapper, two (2) of two (2) boxes of thawed chicken meat dripping on the floor of the walk-in refrigerator, two (2) of two (2) soiled convection ovens, two (2) of four (4) soiled food warmers and a soiled kitchen floor. The findings include: 1. The scoop to the ice machine was stored in a container half full of cloudy water with a 'Mounds' candy wrapper floating inside of the container. 2. Fluid from two (2) of two (2) boxes of thawed chicken was observed dripping on to the floor of the walk-in refrigerator. 3. Two (2) of two (2) convection ovens, two (2) of	F 371	**F371- 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** **1-** 1. The ice scoop holder was vented to allow for drainage and both the scoop and holder were sanitized prior to being used 2. All units were checked and there are no other wall-mounted ice scoops. 3. The staff were in-serviced on proper storage and cleaning of equipment on 9/14/11, 9/21/11 and 9/16/11. These in-services will be repeated on 11/3/11. 4. The Food & Nutrition QA/QI Coordinator inspects weekly. The Operations manager and Director will review inspection results and a summary report will be submitted to the QA/QI Director Carroll Manor monthly with findings reported at the quarterly QA/QI meeting **2-** 1. The chicken was pulled, properly stored, repackaged & placed on sheet pans to prevent potential contamination immediately. 2. All refrigerators inspected to ensure no other incidents. 3. The staff was in-serviced on proper and safe food storage and prevention of cross-contamination. Cleaning schedules were posted beginning 9/17/11. 4. The Food & Nutrition QA/QI Coordinator inspects weekly. The Operations manager and Director will review inspection results and a summary report will be submitted to the QA/QI Director Carroll Manor monthly with findings reported at the quarterly QA/QI meeting **3-** 1. The two (2) ovens, two (2) food warmers, and kitchen floor were immediately cleaned 2. All ovens, food warmers, and areas of the kitchen floor were inspected	9/12/11 9/12/11 11/3/11 On-going 9/12/11 9/12/11 11/3/11 On-going 9/12/11 9/12/11

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F 371	Continued From page 19 four (4) food warmers and the kitchen floor were soiled. These observations were made in the presence of Employee #13 who acknowledged the findings at the time of observations.	F 371	3. All staff will be in-serviced on proper cleaning procedures and identified areas have been added to the daily cleaning schedule . 4. The Food & Nutrition QA/QI Coordinator inspects weekly. The Operations manager and Director will review inspection results and a summary report will be submitted to the QA/QI Director Carroll Manor monthly with findings reported at the quarterly QA/QI meeting	11/3/11
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations made during the survey period, September 12 through 19, 2011, it was determined that the facility failed to maintain the garbage refuse area clean and free of debris. The findings include: Two (2) large carts full of plastic storage containers and trash were stored behind the dumpster and were malodorous. These observations were made in the presence of Employee #25 who acknowledged the findings.	F 372	**F372- 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY** 1. The two large carts of plastic storage containers and trash were immediately removed 2. All areas were inspected and checked for improper storage. 3. In-service sessions were done for proper trash disposal procedure. Inspection of trash storage containers was added as part of the daily closing check list. 4. The Food & Nutrition QA/QI Coordinator inspects weekly. The Operations manager and Director will review inspection results and a summary report will be submitted to the QA/QI Director Carroll Manor monthly with findings reported at the quarterly QA/QI meeting	On-going 9/12/11 9/12/11 9/14/11 On-going
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental	F 406		

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F 406	Continued From page 20 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, staff interview and observations for one (1) of one (1) sampled resident, it was determined that facility staff failed to provide specialized rehabilitative services or obtain them from an outside resource (in accordance with §483.75(h) of this part) consistent with the findings of the PASRR [Pre-Admission Screen/Resident Review] Level II Screen for Mental Retardation. Resident #61. The findings include: A medical record review was conducted on September 15, 2011 at 11:48 AM. The face sheet indicated that the resident was admitted December 20, 2002. A PASRR Level II Screen for Mental Retardation dated April 24, 2003 revealed Resident #61 was assessed with Mental Retardation. The screen stipulated that the resident "...could benefit from active treatment as offered in a day program or pre-vocational setting. [S/he] may	F 406	**F406- 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES** 1. The care plan for Resident #61 has been updated for specific rehabilitative services. A request has been initiated to obtain a current PASSR Level II Screen to determine the ongoing need for specialized rehab services 2. All residents with a PASRR Level II screen will have their care plans reviewed and updated as needed 3. . In-services will be conducted for all Social Services staff related to updating care plans for recommendations for specialized rehab service consistent with the PASRR Level II. 4. The Social Services Manager or designee will audit the PASRR Screens of all new admissions and report the findings quarterly to the QA/QI meeting.	9/19/11 11/3/11 11/3/11 On-going

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F 406	Continued From page 21 also benefit from a residential placement in a home like environment, which is handicapped accessible... " A review of the clinical record lacked evidence that the IDT acknowledged, accommodated and/or decided against the active treatment as offered in a day program or pre-vocational setting as stipulated in the Level II screen. A face-to-face interview was conducted with Employee #33 on September 15, 2011 3:30 PM. He/she stated that the resident was very functional. He/she can understand most things on a child level and some adult things. He/she can read, perform cross-word puzzles and participates in structured activities. A face-to-face interview was conducted with Employee #32 on September 15, 2011 at 3:30 PM. He/she stated that the resident was very involved in the activities offered at the facility. Many of the programs that are offered in the " Day-Programs " are similar to the structured activities that the facility provides. There was no evidence that the facility provided or obtained specialized rehab services consistent with the Level II Screen for Resident #61. The record was reviewed on September 15, 2011.	F 406		
F 441 SS=K	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 22 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on observations, record and staff	F 441	**F441- 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **A-** 1. Immediate removal of all non disposable eating dishware and utensils from resident care areas. Provide disposable eating dishware and utensils for all residents receiving evening meal service 9/13/11 and ongoing until resolved A. Contacted the contract vendors to trouble shoot the dishwasher problem. B. Vendor has installed a sanitizer to the dishwasher machine 9/14/11. C. Continue the use of disposable eating dishware and utensils through the noon meal 9/14/11. D. All dishes and utensils were removed and transported to Providence Hospital to be cleaned and stored until the dish machine was repaired. E. All serving utensils and pots and pans are being cleaned and sanitized utilizing the three compartment sink cleaning procedure. F. Dishes will be transported back to Carroll Manor and washed prior to putting them back into circulation. 2. Monitor residents for any gastrointestinal (GI) signs and symptoms for the next 24 – 72 hours. A. Ensure residents use only disposable items until the dishwasher is repaired. B. Create a line listing identifying any negatively affected residents. C. Notify the Medical Director directly if any residents develop GI symptoms. 3. Provide in-service on gastrointestinal signs and symptoms for all nursing staff. A. Provide in-service on proper wash, rinse, and sanitized procedures for the pot sink for dietary staff. B. Provide in-service on proper dishwasher	9/14/11 9/16/11

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 interviews, it was determined that the facility staff failed to maintain the dish machine in safe operating condition, as evidenced by failure to ensure that the dish machine maintained an acceptable final rinse temperature (180 degrees Fahrenheit [F]) to sanitize china/dishware and utensils. Subsequently, residents were observed drinking from dishware that had not been properly sanitized. Food was served with utensils and/or plated atop dishware that had not been properly sanitized. An Immediate Jeopardy (IJ) at CFR 483.65, Infection Control; and cross referenced to CFR 483.70 (c) (2) "Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition" was identified on September 13, 2011 at 5:54 PM. The findings include: At 5:05 PM on September 13, 2011 an observation of the dish machine was conducted. In four (4) of five (5) dish wash cycles observed, the final rinse temperature gauge failed to reach 180 degrees F. The highest temperature observed was 138 degrees F. A face-to-face interview was conducted with Employee #13 at the time of the observation. He/she acknowledged that the final rinse temperature gauge did not reach 180 degrees F in four (4) of five (5) wash cycles observed. Employee #13 stated, " I observed this today (September 13, 2011) at 12:30 PM. I called [company] and they said I think it ' s my booster heater. I then called [the facilities equipment contractor] and they said they would be out here [at the facility] tomorrow. Dinner is being served	F 441	temperature protocols in the event of insufficient temperature for the dietary staff. C. Provide in-service on temperature log protocols in the event of insufficient temperatures for dietary staff. 4. Verify the dishwasher water temperature reaches a minimum of 150 degrees and final rinse temperatures reach 120 degrees in conjunction with chemical sanitizing system before using any non disposables. A. Monitor the dishwasher water ph and temperature three times per meal for the next 72 hours and thereafter the ph and water temperature will then be monitored at all three meals daily. B. Report all findings to the Carroll Manor QI Director monthly.	9/14/11 On-going

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F 441	Continued From page 24	F 441		

now (5:00 PM). The residents are currently eating off china plates and utensils from today's dish machine wash cycle. " Employee #13 was then queried as to who made the decision to send the china and utensils that were not properly sanitized to the resident units for the dinner meal. He/she replied, I made the decision to send the china upstairs. "

Additionally, residents were served and ate lunch off china/dishware and utensils that were washed by the dish machine that did not reach the 180 degrees F for sanitation.

The dish machine temperature logs from April 2011 through September 13, 2011 were reviewed on September 13, 2011 at approximately 4:30 PM. A review of the logs revealed several dates when the dish machine temperatures were recorded to be less than 180 degrees Fahrenheit (F) [the point of sanitation - see chart below].

Dishwasher Temperature Check Sheet
Carroll Manor Food and Nutrition Services Department

Date	Time	Wash Temp	Final Rinse Temp
9/13/11	PM	Not recorded	0 at 12:00
9/2/11	PM	160	160
9/9/11	PM	162	176
6/2 /11	AM	160	179
6/3/11	AM	159	179
6/3/11	PM	158	179
6/4/11	PM	158	178
6/6/11	AM	162	179

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F 441	Continued From page 25 6/6/11 PM 159 170 6/8/11 AM 160 179 6/9/11 PM 180 178 6/10/11 PM 160 No data recorded 6/11/11 PM No data recorded No data recorded 6/14/11 AM 160 179 6/15/11 PM 158 176 6/16/11 PM 160 176 6/17/11 PM 162 179 6/18/11 AM 162 179 4/10/11 AM 160 178 4/18/11 AM 166 162 4/19/11 AM 160 179 4/20/11 AM 164 179 4/21/11 AM 166 179 4/23/11 AM 160 178 4/23/11 PM 160 179 4/24/11 AM 164 179 4/24/11 PM 160 179 4/24/11 (as recorded) PM 160 179 4/25/11 PM 177 179 4/26/11 PM 160 179 4/27/11 AM 164 178 4/28/11 AM 160 179 4/29/11 AM 166 179 4/30/11 AM 162 179 4/30/11 PM No data recorded No data recorded Additionally, after a review of the dish machine and refrigerator/freezer temperature logs, the surveyor asked for copies of all the logs that were reviewed on September 13, 2011 at approximately 4:45 PM. Multiple requests were made for the copies of the temperature logs from 4:40 PM on September 13 to September 14, 2011 at 12:05 PM. At that time Employee #15	F 441		

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F 441	Continued From page 26 provided the surveyor with multiple binders containing temperature logs dating from April 2011 through September 13, 2011. These temperature logs had different hand writing and information that was not the same as the temperature logs that were reviewed on September 13, 2011 at approximately 4:40 PM. The surveyor then requested a copy of what was originally reviewed. Approximately 45 minutes later Employee #15 returned to the surveyor with a copy of the logs that were originally reviewed and stated, [The surveyor was informed] " Employee #13 had them. Employee #13 made them up [the logs] because he/she could not find the original sheets. " Employee #15 apologized and stated that the information in the binders are the original logs. Further Observations: An observation of the dining service on the fourth floor on September 13, 2011 at 5:50 PM revealed residents were escorted to the dining room and seated at tables with place settings that included silverware enclosed inside of a plastic sleeve and glasses filled with water. One resident was observed drinking water from the glass provided. Food was plated with serving utensils. An observation of the dining service on the fifth floor on September 13, 2011 at 5:50 PM revealed residents were seated at tables with glasses filled with water at the table settings.	F 441		

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F 441	Continued From page 27 Residents were observed drinking water from the glasses provided. An observation of the dining service on the first floor on September 13, 2011 at 5:57 PM revealed residents were seated at the dining tables with place settings that included a glass of water, a glass of juice, silverware and napkins. Several residents were observed drinking either water or juice from the glasses provided. Observations of the 2nd and 3rd floor on September 13, 2011 at 5:45 PM revealed dining services had not begun, however; desserts were pre-plated on dishware and stacked on shelves in a transport cart. In summary, residents were observed drinking from dishware that had not been properly sanitized. Food was served with utensils and/or plated atop dishware that had not been properly sanitized. Facility staff failed to implement paper products or other measures to prevent the potential spread of infection. A face-to-face meeting was conducted with Employees #1 and #2 on September 13, 2011 at 5:45 PM. An Immediate Jeopardy (IJ) was called at 5:54 PM on September 13, 2011 for facility's failure to sanitize china/dishware and utensils per standard precautions, the residents were observed drinking/eating with china/dishware that had not been properly sanitized. The allegation of removal of the Immediate Jeopardy situation was received and verified on September 14, 2011 at 3:00 PM and the Immediate Jeopardy was lifted at this time.	F 441		

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F 441	Continued From page 28 B. Based on dining observations, it was determined that facility staff failed to ensure that residents hands were sanitized prior to eating and facility staff serving residents failed to sanitize or cleanse their hands between serving residents and touching inanimate surface areas and staff failed to provide a clean clothing protector for one (1) resident. Residents #97 and #231. The findings include: 1. On September 12, 2011 during a lunch dining observation, staff failed to follow proper hand hygiene practices as follows: Residents were escorted directly from the dayroom to the dining room for the lunch meal. Containers of hand sanitizer were observed atop tables in the dining room and available for resident use. There was no evidence that the residents were offered the opportunity to cleanse their hands prior to being served. Staff who passed trays and provided tray set-up failed to cleanse/sanitize their hands between serving meals and handling inanimate objects such as the positioning chairs and touching counter tops. Staff who assisted residents with meal consumption failed to cleanse/sanitize hands between residents. Resident #97 and Resident #231 were seated at the same table. Employee	F 441	**F 441- 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **B-1A** 1. Staff cleansed/sanitized their hands between assisting residents at the next meal consumption. 2. All staff will cleanse/sanitize their hands between assisting residents during meal times. 3. All staff will be in-serviced on the infection control policy regarding hand hygiene. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting. **B-1B** 1. Resident # 97 & 23's hands were sanitized prior to eating the next meal. 2. All resident's hands will be sanitized prior to be being served at meal time. 3. All staff will be in-serviced on the infection control policy regarding hand hygiene. 4. Monthly audits will be conducted by Nurse Manager or designee to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going 9/12/11 11/3/11 11/3/11 On-going

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F 441	Continued From page 29 #22 assisted both residents with meal consumption; however, failed to cleanse/sanitize his/her hands between assisting each resident. 2. An observation of the lunch meal on September 12, 2011 at 12:35 PM revealed facility staff failed to maintain proper infection control practices during assistance with dining as follows: Employee #21 was observed picking up a clothing protector off of the floor and placing the protector directly on the resident prior to feeding. An interview with the employee after the observation confirmed that a new clothing protector should have been provided for the resident.	F 441	**F 441- 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **B-2** **2-** 1. Resident was provided with new clothing protector at the next meal time. 2. All residents will be provided with new clothing protectors at each meal time. 3. All staff will be in-serviced on infection control practices. 4. Monthly audits will be conducted by Infection Control Nurse to ensure compliance and the results will be submitted to the Director of Nursing for presentation at the quarterly QA/QI meeting.	9/12/11 11/3/11 11/3/11 On-going
F 456 SS=K	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, record and staff interviews, it was determined that the facility staff failed to maintain the dish machine in safe operating condition, as evidenced by failure to ensure that the dish machine maintained an acceptable final rinse temperature to sanitize china/dishware and utensils. Subsequently, residents were observed drinking from dishware that had not been properly sanitized. Food was served with utensils and/or plated atop dishware that had not been properly sanitized. An Immediate Jeopardy (IJ) at CFR 483.70 (c)	F 456	**F483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** 1. Immediate removal of all non disposable eating dishware and utensils from resident care areas. Provide disposable eating dishware and utensils for all residents receiving evening meal service 9/13/11 and until resolved: A. Contacted the contract vendors to trouble shoot the dishwasher problem. B. Vendor has installed a sanitizer to the dishwasher machine 9/14/11. C. Continue the use of disposable eating dishware and utensils through the noon meal 9/14/11. D. All dishes and utensils were removed and transported to Providence Hospital to be cleaned and stored until the dish machine was repaired. E. All serving utensils and pots and pans are being cleaned and sanitized utilizing the three compartment sink cleaning procedure.	

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F 456	Continued From page 30 (2) "Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition" was identified on September 13, 2011 at 5:54 PM. The findings include: The dish machine temperature logs from April 2011 through September 13, 2011 were reviewed on September 13, 2011 at approximately 4:30 PM. A review of the logs revealed several dates when the dish machine temperatures were recorded to be less than 180 degrees Fahrenheit (F) [the point of sanitation - see chart below]. Dishwasher Temperature Check Sheet Carroll Manor Food and Nutrition Services Department Date Time Wash Temp Final Rinse Temp 9/13/11 Pm Not recorded 0 at 12:00 9/2/11 Pm 160 160 9/9/11 Pm 162 176 6/2 /11 Am 160 179 6/3/11 Am 159 179 6/3/11 Pm 158 179 6/4/11 Pm 158 178 6/6/11 Am 162 179 6/6/11 Pm 159 170 6/8/11 Am 160 179 6/9/11 Pm 180 178 6/10/11 Pm 160 No data recorded 6/11/11 Pm No data recorded No data recorded 6/14/11 Am 160 179	F 456	F. Dishes will be transported back to Carroll Manor and washed prior to putting them back into circulation 2. Monitor residents for any gastrointestinal (GI) signs and symptoms for the next 24 – 72 hours A. Ensure residents use only disposable items until the dishwasher is repaired. B. Create a line listing identifying any negatively affected residents. C. Notify the Medical Director directly if any residents develop GI symptoms. 3. Provide in-service on gastrointestinal signs and symptoms for all nursing staff. A. Provide in-service on proper wash, rinse, and sanitized procedures for the pot sink for dietary staff. B. Provide in-service on proper dishwasher temperature protocols in the event of insufficient temperature for the dietary staff. C. Provide in-service on temperature log protocols in the event of insufficient temperatures for dietary staff. 4. Verify the dishwasher water temperature reaches a minimum of 150 degrees and final rinse temperatures reach 120 degrees in conjunction with chemical sanitizing system before using any non disposables. A. Monitor the dishwasher water ph and temperature three times per meal for the next 72 hours and thereafter the ph and water temperature will then be monitored at all three meals daily. B. Report all findings to the Carroll Manor QI Director monthly.	9/14/11 9/16/11 9/14/11 On-going

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F 456	Continued From page 31 6/15/11 Pm 158 176 6/16/11 Pm 160 176 6/17/11 Pm 162 179 6/18/11 Am 162 179 4/10/11 Am 160 178 4/18/11 Am 166 162 4/19/11 Am 160 179 4/20/11 Am 164 179 4/21/11 Am 166 179 4/23/11 Am 160 178 4/23/11 Pm 160 179 4/24/11 Am 164 179 4/24/11 Pm 160 179 4/24/11 (as recorded) Pm 160 179 4/25/11 Pm 177 179 4/26/11 Pm 160 179 4/27/11 Am 164 178 4/28/11 Am 160 179 4/29/11 Am 166 179 4/30/11 Am 162 179 4/30/11 Pm No data recorded No data recorded At 5:05 PM on September 13, 2011 an observation of the dish machine was conducted. In four (4) of five (5) dish wash cycles observed, the final rinse temperature gauge failed to reach 180 degrees F. A face-to-face interview was conducted with Employee #13 at the time of the observation. He/she acknowledged that the final rinse temperature gauge did not reach 180 degrees in four (4) of five (5) wash cycles observed. Employee #13 stated, " I observed this today (September 13, 2011) at 12:30 PM. I called [company] and they said I think it ' s my booster heater. I then called [the facilities equipment	F 456		

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F 456	Continued From page 32	F 456		

contractor] and they said they would be out here [at the facility] tomorrow. Dinner is being served now (5:00 PM). The residents are currently eating off china plates and utensils from today's dish machine wash cycle. " Employee #13 was then queried as to who made the decision to send the china and utensils that were not properly sanitized to the resident units for the dinner meal. He/she replied, " I made the decision to send the china upstairs. "

Further Observations:

An observation of the dining service on the fourth floor on September 13, 2011 at 5:50 PM revealed residents were escorted to the dining room and seated at tables with place settings that included silverware enclosed inside of a plastic sleeve and glasses filled with water. One resident was observed drinking water from the glass provided. Food was plated with serving utensils.
An observation of the dining service on the fifth floor on September 13, 2011 at 5:50 PM revealed residents were seated at tables with glasses filled with water at the table settings. Residents were observed drinking water from the glasses provided.
An observation of the dining service on the first floor on September 13, 2011 at 5:57 PM revealed residents were seated at the dining tables with place settings that included a glass of water, a glass of juice, silverware and napkins. Several residents were observed drinking either water or juice from the glasses provided.
Observations of the 2nd and 3rd floor on September 13, 2011 at 5:45 PM revealed dining services had not begun, however; desserts were

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F 456	Continued From page 33 pre-plated on dishware and stacked on shelves in a transport cart. In summary, residents were observed drinking from dishware that had not been properly sanitized. Food was served with utensils and/or plated atop dishware that had not been properly sanitized. A face-to-face meeting was conducted with Employees #1 and #2 on September 13, 2011 at 5:45 PM. An Immediate Jeopardy (IJ) was called at 5:54 PM on September 13, 2011 for facility's failure to sanitize china/dishware and utensils per standard precautions, the residents were observed drinking/eating with china/dishware that had not been properly sanitized. The allegation of removal of the Immediate Jeopardy situation was received and verified on September 14, 2011 at 3:00 PM and the Immediate Jeopardy was lifted at this time.	F 456		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made during the survey period, September 12 through 19, 2011, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects observed on the third, fourth and fifth floor units and in the main kitchen.	F 469	**F469- 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM** 1. The trash cans in the described areas were immediately cleaned thoroughly checked. 2. All areas were checked and inspected for any other occurrence. 3. Fly lights have been installed at the loading dock and canteen areas. In-service sessions have been scheduled on proper trash removal and cleaning techniques to reduce fruit flies. Trash cans and drains have been added to the daily EVS cleaning schedule. Staff has also been properly instructed on how to clean the drains in each pantry. 4. The Food and Nutrition QA/QI Coordinator Ongoing inspects weekly. The Operations Manager and Director will review inspections. A summary report will be submitted to the QA/QI Director at Carroll Manor monthly	9/12/11 9/12/11 11/3/11 On-going

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F 469	Continued From page 34 The findings include: 1. Flying insects were observed by the surveyrs on the third, fourth and fifth floor units. 2. Insects were observed numerous times flying in the main kitchen area. These observations were made at different times during the survey.	F 469		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the administration failed to use its resources effectively and efficiently to maintain the facilities dish machine and failure to practice standard precautions for the well-being of residents. The findings include: An observation of the dish machine final wash cycle on September 13, 2011 at 5:05 PM noted a temperature reading of 138 degrees Fahrenheit (F) and not 180 degrees F as required at the point of sanitization. Through interview with	F 490	**F490- 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING** 1. Immediate removal of all non disposable eating dishware and utensils from resident care areas. Provide disposable eating dishware and utensils for all residents receiving evening meal service 9/13/11 and ongoing until resolved: A. Contacted the contract vendors to trouble shoot the dishwasher problem. B. Vendor has installed a sanitizer to the dishwasher machine 9/14/11. C. Continue the use of disposable eating dishware and utensils through the noon meal 9/14/11. D. All dishes and utensils were removed and transported to Providence Hospital to be cleaned and stored until the dish machine was repaired. E. All serving utensils and pots and pans are being cleaned and sanitized utilizing the three compartment sink cleaning procedure. F. Dishes will be transported back to Carroll Manor and washed prior to putting them back into circulation.	9/14/11

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	095034	A. BUILDING _____ B. WING _____	09/19/2011

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 490	Continued From page 35 Employee#13 on September 13, 2011 at the time of the aforementioned observation it was revealed that the a low temperature reading had been observed earlier in the day (by Employee #13) and the decision was made to proceed with use of dish ware (by Employee #13) for the noon and dinner meal service (although the dish ware had not been properly sanitized). Interview with Employee #1 and 2 on September 13, 2011, revealed there are constraints for the hospital based nursing facility to fully manage all aspects of dietary services. In addition the monitoring of dish machine temperatures and surveillance activities as it relates to reporting of equipment malfunctions was not consistent as it pertains to administrative oversight. An Immediate Jeopardy was identified on September 13, 2011 at 5:54 PM for failure to to ensure proper sanitation of dish ware and to prevent the potential spread of infection. Cross reference to CFR 483. 65 Infection Control, Prevent Spread of Infection F441, and CFR 483.70(c)(2) Essential Equipment, Safe Operating Condition F456, and CFR 483.75(o)(1) Quality Assurance and Assessment Committee F520.	F 490	2.Monitor residents for any gastrointestinal (GI) signs and symptoms for the next 24 – 72 hours. A. Ensure residents use only disposable items until the dishwasher is repaired. B. Create a line listing identifying any negatively affected residents. C. Notify the Medical Director directly if any residents develop GI symptoms. 3. Provide in-service on gastrointestinal signs and symptoms for all nursing staff. A. Provide in-service on proper wash, rinse, and sanitized procedures for the pot sink for dietary staff. B. Provide in-service on proper dishwasher temperature protocols in the event of insufficient temperature for the dietary staff. C. Provide in-service on temperature log protocols in the event of insufficient temperatures for dietary staff. D. The written process for the dish machine sanitation standards has been revised to include the notification process and needed actions. 4. The dietary operations manager will meet with the Administrator/designee weekly to review dietary sanitation logs. All findings will be reported to the Carroll Manor QI Director monthly and the QA Committee quarterly	9/16/11 10/31/11 On-going
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 493		

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F 493	Continued From page 36 the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the governing body failed to establish and implement polices regarding the management and operation of the facility as evidenced by failure to maintain the facility's dish machine in good operation and failure to practice standard precautions for the well-being of residents to prevent the spread of infection when dish ware is not properly sanitized. The findings include: An observation of the dish machine final wash cycle on September 13, 2011 at 5:05 PM noted a temperature reading of 138 degrees Fahrenheit (F) and not 180 degrees F as required at the point of sanitization. Through interview with Employee#13 on September 13, 2011 at the time of the aforementioned observation it was revealed that the a low temperature reading had been observed earlier in the day (by Employee #13) and the decision was made to proceed with use of dish ware (by Employee #13) for the noon and dinner meal service (although the dish ware had not been properly sanitized). Interview with Employee #1 and 2 on September 13, 2011, revealed there are constraints for the hospital based nursing facility to fully manage all aspects of dietary services. In addition the monitoring of dish machine temperatures and	F 493	**F493- 483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN** 1. Immediate removal of all non disposable eating dishware and utensils from resident care areas. Provide disposable eating dishware and utensils for all residents receiving evening meal service 9/13/11 and ongoing until resolved: A. Contacted the contract vendors to trouble shoot the dishwasher problem. B. Vendor has installed a sanitizer to the dishwasher machine 9/14/11. C. Continue the use of disposable eating dishware and utensils through the noon meal 9/14/11. D. All dishes and utensils were removed and transported to Providence Hospital to be cleaned and stored until the dish machine was repaired. E. All serving utensils and pots and pans are being cleaned and sanitized utilizing the three compartment sink cleaning procedure. F. Dishes will be transported back to Carroll Manor and washed prior to putting them back into circulation. 2.Monitor residents for any gastrointestinal (GI) signs and symptoms for the next 24 – 72 hours. A. Ensure residents use only disposable items until the dishwasher is repaired. B. Create a line listing identifying any negatively affected residents. C. Notify the Medical Director directly if any residents develop GI symptoms.	9/14/11 9/16/11

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F 493	Continued From page 37 surveillance activities as it relates to reporting of equipment malfunctions was not consistent as it pertains to the governing body oversight of the facility's operations. An Immediate Jeopardy was identified on September 13, 2011 at 5:54 PM for failure to to ensure proper sanitation of dish ware and to prevent the potential spread of infection. Cross reference to CFR 483. 65 Infection Control, Prevent Spread of Infection F441, and CFR 483.70(c)(2) Essential Equipment, Safe Operating Condition F456, and CFR 483.75(o)(1) Quality Assurance and Assessment Committee F520.	F 493	3. Provide in-service on gastrointestinal signs and symptoms for all nursing staff. A. Provide in-service on proper wash, rinse, and sanitized procedures for the pot sink for dietary staff. B. Provide in-service on proper dishwasher temperature protocols in the event of insufficient temperature for the dietary staff. C. Provide in-service on temperature log protocols in the event of insufficient temperatures for dietary staff. D. The written process for the dish machine sanitation standards has been revised to include the notification process and needed actions. 4. The dietary operations manager will meet with the Administrator/designee weekly to review dietary sanitation logs. All findings will be reported to the Carroll Manor QI Director monthly and the QA Committee quarterly. The administrator will report quarterly QA results to the hospital CEO and Senior VP of Clinical Operations	10/31/11 On-going
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		

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F 520	Continued From page 38 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to develop and implement comprehensive system to ensure that appropriate plans of action to correct identified concerns with the dish machine final rinse temperatures. The findings include: A review of the temp logs for June 2011 through September 13, 2011 revealed that dish machine temperatures on multiple days failed to reach 180 degrees Fahrenheit at the final rinse to sanitize the dishes and/or utensils. A face-to-face interview was conducted with Employee #14 on September 19, 2011 at 10:59 AM. He/she stated, "I review the temperature logs. I told the manager on duty and I informed Ecolab. I ask for the sheets [temperate logs]. I make sure that everything is corrected. The staff [non- dietary staff] over here do not have anything to do with the corrections. Everything is done [corrected] from the hospital. All dietary staff in this building report to the hospital." When Employee #14 was queried as to what was done	F 520	**F520- 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS** 1. Immediate removal of all non disposable eating dishware and utensils from resident care areas. Provide disposable eating dishware and utensils for all residents receiving evening meal service 9/13/11 and ongoing until resolved: A. Contacted the contract vendors to trouble shoot the dishwasher problem. B. Vendor has installed a sanitizer to the dishwasher machine 9/14/11. C. Continue the use of disposable eating dishware and utensils through the noon meal 9/14/11. D. All dishes and utensils were removed and transported to Providence Hospital to be cleaned and stored until the dish machine was repaired. E. All serving utensils and pots and pans are being cleaned and sanitized utilizing the three compartment sink cleaning procedure. F. Dishes will be transported back to Carroll Manor and washed prior to putting them back into circulation. 2.Monitor residents for any gastrointestinal (GI) signs and symptoms for the next 24 – 72 hours. A. Ensure residents use only disposable items until the dishwasher is repaired. B. Create a line listing identifying any negatively affected residents. C. Notify the Medical Director directly if any residents develop GI symptoms.	9/14/11 9/16/11

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F 520	Continued From page 39 in the previous months when the dish machine temperate did not reach 180 degrees did the facility serve from paper? That information would come from the manager in the kitchen. I don't recall every going to paper." There was no evidence that facility staff develop and implement appropriate plans of action to correct identified quality deficiencies.	F 520	3. Provide in-service on gastrointestinal signs and symptoms for all nursing staff. A. Provide in-service on proper wash, rinse, and sanitized procedures for the pot sink for dietary staff. B. Provide in-service on proper dishwasher temperature protocols in the event of insufficient temperature for the dietary staff. C. Provide in-service on temperature log protocols in the event of insufficient temperatures for dietary staff. D. The written process for the dish machine sanitation standards has been revised to include the notification process and needed 4. The dietary operations manager will meet with the Administrator/designee weekly to review dietary sanitation logs. All findings will be reported to the Carroll Manor QI Director monthly and the QA Committee quarterly.	10/31/11 On-going