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	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living Carroll Manor	725 Buchanan St., NE Washington, DC 20017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of five (5) sampled residents, facility staff failed to ensure that they followed Resident #1's physician's order to not be assigned a male Certified Nursing Assistant/CNA.The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included Dementia, Congestive Heart Failure, Hypertension and Age Related Macular Degeneration. Review of the resident's medical record revealed the following: A physician's order dated 07/28/24 that directed, Per resident request - every shift, no male CNA. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 10 indicating moderately impaired cognitive status; required supervision or touching assistance for personal hygiene. Review of the nursing assignment sheets and CNA documentation from 02/01/26 to 03/18/26 showed that a male CNA was assigned to and documented that they provided care for Resident #1 on the following dates and shifts:02/03/26, day and evening shift.02/04/26, day shift.02/05/26 and 02/06/26, day and evening shift.02/15/26 and 02/18/26, day shift.02/20/26, evening shift.02/21/26, day shift.03/03/26, 03/12/26, 03/14/26, and 03/15/26 evening shift. The evidence showed that Resident #1 was assigned a male CNA for a total of 15 shifts from 02/01/26 to 03/18/26. During a face-to-face interview on 03/19/26 at 9:40 AM, the findings were brought to the attention of Employee #12 (Assistant Director of Nursing/ADON) and Employee #13 (1st floor Unit Manager). The employees acknowledged the findings with Employee #13 stating, The staff know to not assign a male to [Resident #1]. I will talk to them and make sure that this doesn't happen again.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, for one (1) of five (5) sampled residents, facility staff failed to ensure that adequate supervision was provided, in accordance with Resident #1's person-centered plan of care, to prevent her from eloping from a safe area, without authorization. Subsequently, Resident #1 eloped from the secure Memory Care unit on 02/21/26 at 11:45 AM. During this survey, an Immediate Jeopardy (IJ-J) was identified at 42 CFR 483.25, Quality of Care, F689, Free of Accident Hazards/Supervision/Devices on 03/18/26 at 1:12 PM. The facility's Administrator submitted an abatement plan to the Survey Team that was accepted on 03/18/26 at 5:27 PM. The Survey Team verified implementation of the abatement plan while onsite and the immediacy was lifted on 03/24/26 at 3:38 PM. After removal of the immediacy, the deficient practice was lowered to a scope and severity level of D.The findings included: Review of the facility's Elopement and Wandering Residents last reviewed in January 2026 documented in part:- This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.- Elopement occurs when a resident leaves the premises or a safe area without authorization. - Alarms are not a replacement for necessary supervision. - Adequate supervision will be provided to help prevent accidents and elopements. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included Dementia, Congestive Heart Failure, Hypertension and Age Related Macular Degeneration. A physician's order dated 06/04/25 that directed, Behavior - every shift, monitor resident for behavioral related to. elopement, impaired adjustment. Physician's order dated 07/08/25 directed, Code alert (wander guard bracelet) for safety monitoring, every shift. Check for placement every shift for elopement; Elopement alert: code alert, every shift, check functioning of code alert for elopement. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 10 indicating moderately impaired cognitive status; wandering behavior not exhibited; no functional limitations in range of motion; used a walker mobility device; and wandering/elopement device was used daily. 01/09/26 at 11:37 PM Elopement Risk Screening: Score 27 - assume resident is at risk for elopement. A care plan focus area revised on 02/11/26: [Resident #1] is at risk for elopement related to poor safety awareness. Interventions: follow community elopement evaluation and monitoring process. A care plan focus area revised on 02/11/26: [Resident #1] had impaired behavior related to refusing care and medications. Interventions included: Staff to replace roam alert bracelet (wander guard) as soon as it is known the resident has removed her bracelet; nursing to check and know the whereabouts of resident at all times. A care plan focus area revised on 02/11/26: [Resident #1] hoovers around the main exit door with her friend waiting for someone to allow them to leave. Interventions: keep [Resident #1] safe on the locked unit; [Resident #1] is on high alert for elopement, all must be aware of her high elopement status. 02/20/26: A maintenance logbook documentation of the wander guard system showed that all the Resident Monitoring Systems (wander guard systems) were checked, and all marked as pass. 02/21/26 at 11:00 AM Safety Checklist:- Employee #6 (Certified Nurse Aide/CNA) documented 01 meaning that the resident was observed in her room. Video recording from 02/21/26:11:40 AM, Employee #3 (Food Service Manager) enters the 1st first floor pantry through the doors located right before entry/exit double doors of the Memory Care unit and then leaves the pantry door wide open.11:44 AM, Resident #1 walks up to the dining room doors, located closest to the main entry/exit double doors of the unit, and hoovers there as Employee #4 (Food Pantry Worker) is inside the pantry. At 11:44 AM and 27 seconds, Employee #4 exits the pantry through the other pantry entry/exit door that leads to the dining room At 11:44 AM and 35 seconds, Resident #1 opens the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dining room doors and walking inside.At 11:45 and 32 seconds, Resident #1 walks into the pantry, through the dining room entry/exit doors, pushing her rolling walker and walks out of the still open pantry door located outside of the Memory Care unit, without staff knowledge. At 11:46 AM, Resident #1 walks past two security officers sitting in the main lobby, without a walker, holding a jacket and a bag. It should be noted that Employee #5 (Security Officer) did get up and follow the resident as she walked outside the facility's main entry/exit doors. A Facility Reported Incident (FRI), intake #2785082, submitted to the State Agency on 02/21/26 at 2:07 PM documented in part:I [Employee #8, Nurse Supervisor] was called by security to come outside to identify a person outside at the door with a bag around 11:48 AM. Once outside, I noticed the person was the resident from the first floor (Memory Care unit), [Resident #1]. I called nurses from the first floor who came out to help me with wheelchair to transfer the resident who was continuing to resist to come in. The resident was brought safely back to the first floor. Head-to-toe assessment done. Review of the security camera showed that the resident exited the floor by the kitchen door. Per the staff, the resident does not wear wander guard. She always cuts it off. That was the reason. The alarm did not go off. A new one was put on the resident at this time. During a face-to-face interview on 03/16/26 at 9:00 AM, Resident #1 stated, I wanted to get some air. There's no circulation in this place. I knew I could get out through the pantry because there wasn't anyone there. When I was walking out, no one tried to stop me until I got outside. I had someone coming to get me but then I called and told them don't come anymore. During a face-to-face interview on 03/16/26 at 2:00 PM, Employee #10 (Licensed Practical Nurse/LPN) stated, I was on shift that day (02/21/26) but was not the assigned nurse. I remember I had put a wander guard bracelet on her (Resident #1) leg, I cannot remember which one. The bracelet was functioning just fine; I used the machine to test it. After the incident, we discovered that the resident had a pair of scissors that she used to cut the bracelet off. We found the scissors and the cut [wander guard] bracelet, that were wrapped in paper towels, inside her pocketbook. We are not sure where she got the scissors from, but we took them away. During a face-to-face interview on 03/16/26 at 2:36 PM, Employee #2 (Director of Nursing/DON), it was brought to the employee's attention that Resident #1 had an intervention of nursing to check and know the whereabouts of resident at all times in her refusal of care/treatment care plan. When asked what does nursing to check and know the whereabouts of resident at all times mean, Employee #2 stated, Staff were doing every one-hour checks on the resident's location. When asked would at all times include the times in between the every one-hour safety checks, Employee #2 stated. I can't explain what ?at all times' means. I know staff frequently had eyes on her. The evidence showed that facility staff failed to check and know the whereabouts of Resident #1 at all times and subsequently, the resident was able to elope from the secured Memory Care unit on 02/21/26 at 11:45 AM. Due to these failures, an Immediate Jeopardy (IJ-J) was identified on 03/18/26 at 1:12 PM. An approved abatement plan submitted to the State Agency on 03/18/26 at 5:27 PM entailed: 1. Corrective action for residents noted to have been affected by the deficient practice. Resident #1 is a resident located on the 1st floor memory care unit and has been deemed an elopement risk. On 2/21/2026, the resident was observed outside the facility, unsupervised, by the security officer. The security officer alerted the supervisor. Resident was brought back into the facility by the Supervisor and other first floor staff. Upon re-entering the first floor, resident had a head to toe assessment conducted by her charge nurse and supervisor and no abnormalities were noted. Resident #1's care plan stated that nursing will check and know the whereabouts of the resident at all times. Care plan has been revised, as of 3/18/2026, to reflect that resident will be monitored for her location and whereabouts every 30mins, which is an increase in monitoring as it relates to the facility's standard practices of monitoring for residents who are at risk for elopement every 1 hour. Resident is currently utilizing a wanderguard bracelet that will trigger both doors to the memory care unit and is no longer in possession of scissors to remove the bracelet. Upon discovery of the scissors, the charge nurse spoke with the resident's legal guardian and informed her of what occurred and that resident cannot have access to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	scissors. On February 21, 2026, education was provided to the dining staff by the Dining Manager regarding the pantry door from the dining room side on the importance of locking the door when no one is in the pantry. The pantry door that the resident was able to exit from was made inoperable so that no one could get in or out through that door by Maintenance. Although the pantry door that the resident was able to exit from was made inoperable, staff were able to get in or out the pantry though the door coming from the dining room, in case of an emergency. On March 2, 2026, both pantry doors in which the resident was able to enter and exit from had keypads placed on them and they are no longer able to open unless someone possesses the code. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility will conduct a 100% audit of all residents who are at risk for elopement and ensure that they have behavior monitoring in place for wandering and/or exit seeking behaviors to be completed by 3/18/2026 All residents who are identified as an elopement risk and are exit seeking will have a care plan in place to reflect increased monitoring of every 30 minutes in an effort to ensure that frequent monitoring and supervision is in place for all residents who are at risk for elopement to be completed by 3/18/2026 All residents who are identified as an elopement risk will have a wanderguard put in place and an accompanying order to check for placement and functioning every shift to be completed by 3/18/2026 All residents who are identified as an elopement risk will have a care plan in place identifying their risk for elopement and person centered interventions that are to take place to prevent them from leaving unaccompanied to be completed by 3/18/2026 All residents who are identified as an elopement risk will have orders in place to check their wanderguards for placement and functioning every shift to be completed by 3/18/2026. 3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. All employees will be re-educated on the importance of ensuring that all doors that shouldn't be left open and/or unlocked are properly closed and locked after entry/exit. Education will be provided by the Staffing Educator for the nursing staff and Department Heads will conduct the same education for their departments under the direction of the staffing educator. Education will begin immediately and is ongoing until 100% compliance is achieved. All charge nurses will be re-educated by the Staffing Educator on the process of checking the wanderguard for placement and functioning, including the method in which a wanderguard can be checked to ensure that it is functioning. Education will begin immediately and is ongoing until 100% compliance is achieved. All nursing staff will be educated by the Staffing Educator on the systematic change of increasing monitoring for residents who are at risk for elopement from every hour to every 30 minutes. Education will begin immediately and is ongoing until 100% compliance is achieved. All charge nurses will be educated by the Staffing Educator on the importance of documenting the location of the resident's wanderguard when checking for placement and functioning. Education will begin immediately and is ongoing until 100% compliance is achieved. The systematic change that will take place will include increasing monitoring for residents who are at risk for elopement and are exit seeking from every 1 hour to every 30 minutes. The change will take place on 3/18/2026. Completion Date: March 23, 2026. Cross Reference 22B DCMR Sec. 3210.4.