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	06/16/2026

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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident interviews, the facility staff failed to maintain a safe and comfortable environment by not ensuring facility temperatures ranged from 71 to 81 Fahrenheit. As evidenced by four (4) of four residents who had respiratory diagnoses and/or were prescribed oxygen therapy, whose room temperatures ranged from 82 - 90 Fahrenheit after the facility staff turned off the HVAC system for repair. (Residents #1, #4, #196, and #199) The findings included: According to the Weather Channel, on June 10, 2026, the temperature in the District of Columbia ranged between 73 and 90 Fahrenheit. https://weather.com/weather/monthly/l/c4025fdf0177c872b7fc2e0d09e7c523995ef49e21145e2d2438fe08649(Resident#1 was admitted to the facility on [DATE]. The resident had multiple active diagnoses, including Pulmonary Embolism without Acute Cor Pulmonale.An admission Minimum Date Set assessment dated [DATE] documented, in part, that the resident had a Brief Interview for Mental Status summary score of 15, indicating intact cognitive status. The resident was coded for requiring substantial/maximum assistance from staff for activities of daily living. A care plan dated 05/19/26 documented in part, Problem-Resident requires oxygen therapy related to Shortness of Breath, Approaches (Interventions)- administer oxygen at 2 liters per nasal cannula. Observe oxygen precautions, monitor and report signs of hypoxia, and position the resident in a sitting position for optimal breathing.During an observation at approximately 11:30 AM on 06/10/26, Resident#1 was noted in her room lying in bed. The resident was alert and oriented to name, place, and time. The resident was also receiving oxygen at 2 liters via nasal cannula per oxygen concentrator. When the resident was asked how she was doing? The resident stated, My room is hot. At the time of the observation, Employee #8 (Maintenance Mechanic) took the temperature of the resident's room using a laser thermometer. The resident's ambient room temperature was measured to be 90 Fahrenheit. Employee #8 stated that contractors were currently on-site working on the HVAC system. 2. Resident#4 was admitted to the facility on [DATE] with multiple diagnoses, including Personal History of Other Malignant Neoplasm of Bronchus Lung, Chronic Obstructive Pulmonary Disease, Cardiac Defibrillator, and Generalized Muscle Weakness. A quarterly Minimum Data Set assessment dated [DATE] documented, in part, that the resident had a Brief Interview for Mental Status summary score of 15, indicating intact cognitive status. The resident was also coded for being dependent on staff assistance with activities of daily living. A care plan dated 04/26/26 documented in part, Problem-[Resident's name] has potential for Shortness of Breath and/or respiratory complications related to history of diagnosis Chronic Obstructive Pulmonary Disease/Emphysema.Approach (Intervention)-Assess contributing factors or triggers to respiratory distress and take corrective action, Monitor for complications such as dyspnea, shortness of air[breath], cyanosis, or tachypnea, monitor oxygen saturation and administer oxygen per physician orders. During an observation at approximately 12 PM on 06/10/26, Resident #4 was observed lying in bed, alert and oriented to name, place, and time. When was the resident asked how she was doing? The resident stated, I'm not comfortable because it's hot in here. At the time of the observation, Employee #8 took the (continued on next page)

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

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	temperature of the resident's room using a laser thermometer. The resident's ambient room temperature was measured to be 88.2 Fahrenheit. Employee #8 stated that contractors were currently on-site working on the HVAC system. 3. Resident #196 was admitted to the facility on [DATE] with multiple diagnoses, including Chronic Respiratory Failure with Hypoxia, Obstructive Sleep Apnea, Asthma, Paraplegia, and Morbid Obesity. A care plan dated 05/22/26 documented in part, Problem-Resident requires oxygen therapy related to asthma and history of hypoxia.Approaches (Interventions)- monitor and report signs of hypoxia, monitor and document respiratory status, provide calm environment free from stimuli to reduce/prevent anxiety.A care plan dated 05/26/26 documented in part, Resident is at risk for Shortness of Breath/Respiratory Distress related to asthma.Approaches (Interventions)- administer oxygen at 2 liters per nasal cannula, monitor and report signs of respiratory distress, monitor lung sounds every shift.An admission Minimum Data Set assessment dated [DATE] documented, in part, that the resident had a Brief Interview for Mental Status summary score of 15, indicating intact cognitive status. The resident was coded for requiring partial and total assistance from staff for activities of daily living, shortness of breath or trouble breathing while lying flat, and using oxygen therapy.An observation at approximately 12:15 PM on 06/10/26 revealed Resident#196 in her room, lying in bed with the head of the bed elevated. The resident was alert and oriented to name, place, and time. Additionally, the resident appeared to have sweat on her forehead and chest. The resident was asked if she was sweating. The resident stated, Yes, because it is very hot in here. I couldn't sleep last night. Also, an oxygen concentrator was observed that was not in use. The resident stated, I only use oxygen when I need it. I don't need it right now. And when they [nurses] turn it [oxygen concentrator] on, the room gets hotter. And I'm already miserable with the temperature of the room right now. At the time of the observation, Employee #8 took the temperature of the resident's room using a laser thermometer. The resident's ambient room temperature was measured to be 88.2 Fahrenheit. Employee #8 stated that contractors were currently on-site working on the HVAC system. During a face-to-face interview at approximately 12:45 PM on 06/10/26, Employee #9 (Director of Maintenance) stated that the HVAC system was turned off this morning (6/10/26) to repair a leaking pipe. When asked how will they address the excessive ambient temperatures in residents' rooms? The employee stated that the work on the HVAC system would be completed today by 1 PM. The facility would cool down approximately 2 after the repair is completed. The employee stated that they had about 3 portable fans in residents' room. And they planned to purchase 10 more portable fans for other residents' rooms. It should be noted that the employee failed to provide the specific time the HVAC system was turned off on 06/10/26. And the facility did not purchase an additional 10 portable fans. During a face-to-face interview at approximately at 12:50 PM, on 06/10/26 Employee #3 (RN/Unit Manager) stated that they were offering cool wash clothes and providing hydration (cold water, juice, popsicles and sherbet) for residents to address the elevated temperatures in the facility. During a face-to-face interview at approximately 1PM on 06/10/26, Employee #1 (Administrator) stated she was not aware the HVAC system had been turned off or that the resident's room had excessive temperatures. She said that she was just coming into work today, but she would speak with her staff to find out when the HVAC was turned off. Additionally, the employee stated that she will make the survey team aware of her findings. It should be noted that the Administrator did not inform the survey team of her findings. 4. Resident #199 was admitted to the facility on [DATE] with multiple diagnoses, including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, and Need for Assistance with Personal Care. A care plan dated 05/30/26 documented in part, Problem- Resident requires oxygen therapy related to respiratory failure.Approaches (Interventions)-Administer oxygen at 4 liters via nasal cannula.Keep room cool.monitor and report signs of hypoxia.An admission Minimum Data Set assessment dated [DATE] documented, in part, that the resident had a Brief Interview for Mental Status summary score of 15, indicating intact cognitive status. The resident was coded as requiring partial to total assistance from staff for activities of daily living; shortness of breath or trouble (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing while lying flat; shortness of breath or trouble breathing with exertion; and use of oxygen therapy.During an observation at approximately 3:45 PM on 06/10/26, Resident#199 was in her room, lying in bed with the head of the bed elevated. When the resident was asked, How was she feeling? She stated, I'm hot. At the time of the observation, Employee #8 took the temperature of the resident's room using a laser thermometer. The resident's ambient room temperature was measured to be 85 degrees Fahrenheit. During a face-to-face interview at approximately 4 PM on 06/10/26, Employee #8 stated that the contractors on-site today to repair the HVAC system did not complete the repair. And they would return on 06/11/26 to continue working on the HVAC system. Additionally, the employee stated that the facility will order spot coolers (portable air conditioning units) for Units 2, 3, 4, and 5. Please note: Because Unit 1's temperature levels ranged between 78 and 81 Fahrenheit, the facility did not order a portable air conditioner for that unit on 06/10/26. Based on these findings, an Immediate Jeopardy (IJ-L) was identified at 42 CFR 483.10, Resident Rights, F584, Safe/Clean/Comfortable/Homelike Environment on June 10, 2026 at 7PM.The facility's staff failed to provide a safe and comfortable environment with temperature levels ranging from 71 to 81 degrees Fahrenheit (F) in resident rooms and common areas. The findings revealed that the potential for serious harm was likely to occur as extreme/excessive heat and/or temperatures may likely result in compromised respiratory state and/or hyperthermia for Residents' #1,#4,#196,and #199 who were dependent on supplemental oxygen. The facility's Administrator submitted a corrective action plan to the Survey Team that was accepted on June 11, 2026 at 2:14 AM that documented the following: 1. Corrective action for residents noted to have been affected by the deficient practice. The Facilities Director contacted [vendor named]. to repair corroded pipe. On 6/10/26 At 7:30 am the vendor arrived at the community. Corroded Pipe was replaced. The chiller was turned off on 6/9/26 at 7:00pm was turned back on at 12:30 pm on 6/10/26. Ambient room temperatures returned to acceptable range by 7:00 pm on 6/10/26. A work-order was submitted to United Rentals at 12:18pm on 6/10/26 for temporary cooling units to be delivered to the facility by the Senior Director of Operational Excellence, which did not arrive. The Facilities Manager started to attempt to contact United Rentals for an estimated time of arrival at 17:07, 17:09, twice at 17:52, and again at 17:55. Unfortunately, United Rentals never responded to the calls. The Facilities Manager then called Axis at 1821 .The Account Manager from Axis responded to the Facilities Manager at 18:25. At that time, a work order was placed at 18:25 on 6/10/26 with Axis to obtain (6) spot coolers. The [vendor named]delivered a total of (6) spot coolers at approximately 8:20pm for the units. The Spot Coolers were placed on each of the units by 9:30 pm on 6/10/26 as a back up to maintain the temperatures. Facilities team began taking ambient room temperatures every hour beginning at 11:00 am for Resident Rooms 322, 327, 324, 330, 342, 343, 355, 331, 345, 526, 621, 515, 501, 222, 224, 226, 442, 444, 446, 451, 542, 545, 553, 554, 556 until appropriate temperatures are maintained. On 6/10/26 in house RNs and LPNs assessed all residents with oxygen therapy by 6:00 pm . No significant respiratory findings noted. Residents were made comfortable and provided drinks and cool wash cloths. Sherbet was added to the lunch meal provided to residents as additional dessert by nutrition services to residents who wished to have it. Activities staff provided popsicles to residents on 6/10/26 at 2:00 pm on all floors On 6/10/26, in house nursing Associates passed additional ice water to residents, cold washcloths were provided to residents, ice tea was made by nutrition services and offered in addition to the water provided to all residents able to drink by mouth. Available fans were provided to residents in rooms 515, 521 and 233 by the nursing staff on 6/10/26 by the Director of Nursing by 12:00 pm. On 6/10/26 Residents in room [ROOM NUMBER] and 528 were temporarily moved to 249 and 251 for increased comfort in temperature by the Director of Nursing. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? Ambient Temperatures for all resident rooms located on the 2nd floor, 3rd floor, 4th floor, 5th floor and 2nd floor dining room, 3rd floor dining room, 4th floor dining room, 5th floor dining room, 2nd floor, 4th floor and 5th floor common areas, hallways, hallway vents and elevator areas were checked and by Facilities Management team (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	every 1 hour starting at 11am. All other residents in the community were evaluated by in house RNs and LPNs on 6/10/26 by 12:00 midnight and no significant findings noted. The Medical Director was notified by the Director of Nursing on 6/10/26 at 9:09 pm. 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 facilities management employees will be re-educated on the importance of ensuring that all patient areas are within regulatory temperature range of 71 to 81 degrees Fahrenheit and preventative measures are put in place prior to Maintenance mechanics being conducted to maintain appropriate temperatures by the Executive Director on 6/10/26 by 11:30pm Ad Hoc QAPI was held with the Senior Director of Operational Excellence, Chief Operations Officer, Director of Clinical Operations, Director of Nursing, Executive Director, Director of Clinical Operations/Regulatory, Director of Business Operations on 6/10/26 at 8:30pm. The Ad Hoc QAPI committee reviewed the existing Emergency planning manual section P: Severe Weather/Extreme Temperatures/Winter [NAME] on 6/10/26 and updated it to be more specific to planning. 4. Ongoing Monitoring Under the direction of the Quality Assurance and Process Improvement (QAPI) Committee, the Facilities Director or designee will audit ambient room temperatures every hour x 48 hours then every 8 hours x 3 days, then weekly ongoing to ensure the ambient temperature is maintained. Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until otherwise determined by QAPI. The administrator is responsible for ensuring ongoing compliance. Date of Compliance: 6/10/26.Verification for the removal of the immediacy was performed by the Survey Team onsite on June 11, 2026, at 4PM.Cross Reference 22B DCMR Sec. 3238.3

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interviews for one (1) of 53 sampled residents, it was determined that the facility staff failed to notify the resident and resident representative of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge. Resident #195. The findings included: A facility policy titled ?Transfer or Discharge, Preparing a Resident for' with a next review date of 01/2027 documented, in part: When a resident is scheduled for transfer or discharge, the social worker, or designee, will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented and This plan will be reviewed with the resident, and/or his her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility and Nursing services is responsible for: 1. Obtaining orders for discharge. Resident #195 was admitted to the facility on [DATE] with multiple diagnoses that included: Arthritis, Osteoporosis, Deep Vein Thrombosis, Urinary Tract Infection and History of Falls. A review of a complaint intake [#3028339] received by the State Agency on 05/22/26 at 1:33 PM documented, in part: .states that [Facility name] is performing an unsafe discharge and that a discharge meeting was never held. During a face-to-face interview conducted on 06/09/26 at approximately 1:57 PM with Employee #3 (Assistant Director of Nursing) she stated, in part: The son, I saw him on the day of discharge [05/19/26] and the staff didn't know about the discharge because it was in the afternoon I was making rounds and he said he needed a wheelchair to take his mother home. I asked why and he said she [Resident #195] was discharged . I asked who told you your mom was discharged and he said that the Social Worker did the discharge in the patient's room. During the morning meeting, the next day, I brought it up as a concern because of the communication gap that the nursing staff did not know that the resident was being discharged from the facility. She [Social Worker's name] didn't follow the due process for discharge . to list the name of residents to be discharged ; call the Doctor or Nurse Practitioner to get the discharge orders. We [are] supposed to get an order [discharge order] in advance. The nurses didn't know about the discharge; if the resident had her own wheelchair he could've taken her without anybody knowing because we didn't know. I also told the Director of Nursing. After that incident we now have a [discharge] process with Social Services. It should be noted that there was no documented evidence of a physician's discharge order in the resident's record.During a face-to-face interview conducted on 06/10/26 at approximately 09:30 AM with Employee #4 (Social Services Manager) she acknowledged the findings and stated, in part: The former [Social Worker's name], she did the admission and care plan meetings, she was new so she hadn't done a care plan so not really sure if information was communicated to the son and the resident about what the discharge plan was, or any barriers to discharge and I did the discharge planning meeting with the [resident's] son, [physical therapist name] and the resident on the day the resident was discharged [05/19/26]. The Son had reached out to the Ombudsman, and the Ombudsman was asking for discharge planning meeting after the resident's son had contacted them. After I left the room, I don't [didn't] know what happened afterwards. For the discharge folder the process is there's a bin on the unit for all discharges, I pulled the folder from the bin, but I don't recall if I told anyone. The discharge planning meeting should include the Social Worker, Rehab department, and other departments with the resident and family. If other departments aren't available, it's not a complete discharge or IDT (interdisciplinary team) meeting.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interview, the facility's staff failed to ensure that a resident's PASSAR II referral was completed within 30 days of admission for one (1) of 53 sampled residents. (Resident #150). The findings included:Resident #150 was admitted to the facility on [DATE] with multiple diagnoses including Unspecified Psychosis, Anxiety Disorder, and Major Depressive Disorder.A review of the resident's medical record revealed a PASSAR I form dated 04/09/26 that failed to capture that the resident had a history of a serious mental illness. Additionally, the form was incomplete and failed to document if a referral for a PASSAR II was necessary. A care plan dated 04/09/26 documented, Problem- Level II PASARR is not needed. Goal-[Resident's Approach (Intervention)-Level II PASSAR is not needed.During a face-to-face interview at approximately 12PM on 06/01/26, Employee #4 (Director of Social Work) stated that the PASSAR I form dated 04/09/26 was completed incorrectly. She would complete another PASSAR I on 06/01/26 [52 days after admission] and submit a referral for a PASSAR II because of the resident's mental health diagnoses.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and staff interview, for two (2) of 53 sampled residents, the facility staff failed to fully implement the care plan interventions for a Resident who had an unwitnessed fall and failed to develop a care plan to manage an unstageable pressure ulcer for one resident. Residents #146 and #150. 1. Resident #150 was admitted to the facility on [DATE] with multiple diagnoses including Fracture of First Lumbar Vertebra, Abnormalities of Gait Mobility, Generalized Muscle Weakness, Severe Protein-Calorie Malnutrition, and Need for Assistance with Personal Care. A Skin Evaluation Form dated 04/23/26 at 7:25 PM documented in part, Left Buttocks DTI (Deep Tissue Injury) unstageable 30% skin, 20% slough, 50% dermis. Treatment-Cleanse with normal saline, pat dry, apply silver alginate, [and] cover with Optifoam. Occurred where: [NAME] Manor Nursing and Rehab Center [Ascension Health]. Size: length 8.0 cm, width 2.0 cm, depth not applicable. A physician order dated 04/24/26 instructed in part, Cleanse left buttocks DTI with normal saline, pat dry, apply silver alginate, cover with Optifoam one time. During a wound care observation provided by Employee #15 (LPN/Wound Care Nurse) starting at 10:57 AM on 05/22/26, the dressing removed from the left buttocks pressure ulcer had a moderate amount dark color drainage, no smell was noted, size was approximately the size of a quarter, wound bed covered with dark and yellow tissue, and no redness, swelling, or maceration was noted on the peri wound. During a face-to-face interview starting at approximately 3 PM on 05/22/26, Employee #2 (DON) stated that staff should've developed a care plan for the resident's left buttocks pressure ulcer. 2. Resident #146 was admitted to the facility on [DATE] with diagnoses that included: Unspecified Dementia, Chronic Kidney Disease Stage 4, Chronic Embolism and Thrombosis, Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Retention of Urine, Localized Edema, and Unsteadiness on Feet. On 05/28/2026 at 11:21 AM during the facility's recertification survey, the State Surveyor was made aware that Resident #146 had an unwitnessed fall on 06/27/26 per Complaint #3012416 that was emailed to the State agency on 05/28/26. The following post-fall, the following observations of Resident #146 were made: On 05/28/26 at 11:54 AM, Resident #146 was observed asleep in bed, lying supine. The Resident was receiving oxygen (2 liters) via nasal cannula. The Resident was resting on a larger bed (bariatric bed). There was one (1) floor mat on the left side of the bed , and no floor mat on the right side of the Resident's bed. The surveyor observed no other floor mat in the Resident's room. On 05/28/26 at 1:22 PM, during the observation, Employee #20 (Certified Nurse's Assistant/ (CNA) and Employee #19 (Licensed Practical Nurse/LPN) the assigned nurse entered Resident #146's room to change the Resident. There was one floor mat on the left side of the bed. Employee #19 moved the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor mat away from the left side of the Resident's bed to avoid stepping on the mat before assisting the Employee #20 with repositioning the Resident and changing the Resident's pants. The surveyor observed no other floor mat in the Resident's room. On 06//05/26 at 2:15 PM, Resident #146 was observed asleep in bed, lying supine. There was one floor mat on the left side of the bed and no floor mat on the right side of the Resident's bed. The surveyor observed no other floor mat in the Resident's room. A review of Resident #146's medical record revealed: A quarterly Minimum Data Set (MDS) assessment dated [DATE] that documented that Resident #146: had a Brief Interview for Mental Status (BIMS) summary score of, 3, indicating that the resident had severely impaired cognition; required maximal assistance to from facility staff for eating, oral hygiene, upper body dressing, and applying footwear; was dependent on facility staff for toileting, bathing, and personal hygiene; had an indwelling urinary catheter; was frequently incontinent for bowel movements, and had received an anticoagulant within the past seven days of the assessment. A nursing progress note dated 05/27/2026 09:58 AM, which documented: CNA reported to this nurse at 5:30 AM. The resident was observed on the floor. The resident was alert and responsive nursing supervisor was notified and assessed the resident. No apparent injury noted. Assisted the resident back to bed; no pain noted after the fall, neuro check obtained. Physician's orders dated 05/27/26 at 1:14 PM that directed: 1) Fall: Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to the fall. Every Shift. 2) Fall: Physical Therapy Consult x1, Once - One Time 08:00 AM - 01:00 AM, 3) Fall: With Suspected head trauma - Neuro checks Q15 minutes x 4, then Q1 hour x2, then Q2 hours x2, then Q4 hours x2, then Q shift x3 [05:45 AM, 06:00 AM, 06:15 AM, 06:45 AM, 07:45 AM, 08:45 AM, 10:45 AM, 12:45 PM, 04:45 PM, and 08:45 PM]. A care plan initiated on 05/27/26 that documented: Category: Falls [Resident #146] had a fall; Goal: [Resident #146] will not have a fall with injury through the next review date x 90 days; Approaches: Provide resident with a bariatric bed to allow for more space for movement; Fall Mat at both sides of the bed while resident is in bed for safety; PT/OT s/p fall Neurological Assessment x 72 hrs (hours) . A review of the neurological assessments (neuro-checks) on 05/27/26 from 05:45 to 08:59 AM showed no documented evidence that vital signs were taken and progress notes were written (as directed by the instructions of the assessment) and showed no documented evidence of a date or signature by a nurse to indicate that the neuro- check assessment was done and completed. A review of the Resident's treatment administration record for June 2026 showed no dates or times to indicate that the nurses were performing neuro-checks on Resident #146 per the physician's order. A nursing progress note dated 05/27/2026 at 04:27 PM that documented: Resident is alert oriented and verbally responsive, and in no respiratory distress or SOB (shortness of breath) noted at this time .S/P f(status post) all no injuries noted at this time, resident denied any pain when asked. Safety (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions were maintained, the call button was within reach, and the resident was encouraged to call for help at the time. Bed in the lowest position, floor mat in place. Further review of Resident #146's medical record showed no documented evidence that facility staff implemented the post-fall care plan approaches/interventions, which included 72-hour neuro-checks after the Resident's fall on 05/28/26, or floor mat placement on both sides of the Resident's bed. During a face-to-face interview on 05/28/26 at 3:03 PM, when asked if the nurses were performing neuro-checks on Resident #146, Employee #2 (Director of Nursing /DON) stated that she and the nurses were still learning the new electronic health record (eHR) system. She further stated that once the order for neuro-checks was entered onto the Resident's electronic health record, she thought the neuro-check times would automatically populate on the Resident's TAR. When reviewing the neuro-check assessments in the Resident's eHR, she stated that she knew the nurses were doing them per the physician's order, but she had no explanation for why the neuro-checks were not completed in the Resident's eHR, or why the nurses were not signing and dating them. During a telephone interview on 06/15/26 at 1:33 PM, Employee #21 (CNA) stated, I was not assigned to the Resident for care that day, but as I was passing by the Resident's room, I noticed Resident #146 was on the floor. She was facing the door beside her bed on the floor. We put her in bed. When I saw her the next day, there was a floor mat only on the left side of the bed. During a telephone interview on 06/15/26 at 2:53 PM, Employee #22 (LPN), stated that she was assigned to Resident #146 when the CNA reported that the Resident was on the floor. The Employee further stated that [Name of Resident#146] was assisted back to bed, and an assessment was done. The nurses then started neuro-checks and documented them in the Resident's chart. They moved the Resident to another room across the hall. When I observed the Resident, her bed had 1/2 headrails up on both sides, and there was one floor mat on the side of her bed facing the door. During a face-to-face interview on 06/05/26 at 2:18 PM with Employee #23 (Registered Nurse/Unit Manager), when asked about the floor mats, she stated that during her rounds, she checked to make sure the Resident had floor mats on both sides of the bed. She then added that sometimes, before feeding or providing care for the Resident. The CNAs will remove the floor mats, and sometimes they forget to put them back. When the surveyor discussed her post fall observations of the Resident's bed with only one floor mat, the Employee acknowledged the finding and made no further comment

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	06/16/2026

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, staff interview, and resident interview, the facility's staff failed to follow up with a resident's physician for cataract surgery for one (1) of 53 residents.(Resident #157)The findings included:Resident #157 was admitted to the facility on [DATE] with multiple diagnoses including Cataracts of Right and Left Eye, Dry Eyes, and Hypertension Retinopathy.A progress note dated 08/25/25 at 4:01 PM documented in part, Resident came back from her appointment with Dr. [NAME]. She was seen for a chief complaint of follow-up ocular hypertension involving the left eye and right. The symptoms are associated with blurred vision and are mild in severity. [Physician's name] recommended that resident should go to [local hospital] Ophthalmology for cataract evaluation.A progress note dated 09/29/25 at 12:55 PM documented in part, Resident left.facility for cataract evaluation.[Physician's name] recommended eye surgery at [hospital's name].A care plan meeting progress note dated 10/30/26 at 4:01 PM documented in part, Resident has an upcoming cataract surgery, all recommended clearances are complete, awaiting call back from eye doctor for available date for resident's eye surgery.During a face-to-face interview at 11:17 AM on 06/08/25, Employee #17 (ADON) stated that the resident completed all pre-op tests for cataract surgery. The employee also said it was an oversight that staff did not call the physician to schedule the surgery. Additionally, the employee stated that staff had made an appointment for 07/17/26 for the resident to start the process again.

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	06/16/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility staff failed to provide the necessary treatment and services to prevent the development and progression of pressure ulcers (bedsores) for two (2) of two residents who developed pressure ulcers that were first observed at advanced stages Residents # 150 and #87. 1. Resident #150 was admitted to the facility on [DATE] with multiple diagnoses including Fracture of First Lumbar Vertebra, Abnormalities of Gait Mobility, Generalized Muscle Weakness, Severe Protein-Calorie Malnutrition, and Need for Assistance with Personal Care. An admission nursing progress note dated 04/09/26 at 6:06 PM documented in part, Resident is alert, oriented and verbally responsive. She's able to make his [her] needs known. Respiration is even and unlabored with no signs of respiratory distress. Skin is warm to touch, redness and dryness noted towards perineal, right groin and sacral area. Nursing staff will continue with the current plan of care, she remains in a stable condition. Vital signs: blood pressure 122/78, pulse 74, temperature 98, 18, oxygen saturation on room air 98%. admission skin evaluation forms dated: 04/09/26 at 10:48 PM documented in part, Spine Thoracic Lumbar surgical site with 14 staples. Treatment-monitor every shift. Occurred where - [local hospital's name]. 04/09/26 at 10:55 PM documented in part, Sacral Ulcer with redness/Moisture Acquired Skin Damage. Treatment-Cleanse sacral area with normal saline apply z-guard after incontinent care. Occurred where - [local hospital's name]. Stage-2. 04/09/26 at 11:18 PM documented in part, Right Groin Moisture Associated Skin Damage. Treatment area was blank. Occurred where - [local hospital's name]. A physician order dated 04/09/26 instructed in part, Shower Day twice weekly on Tuesday and Fridays 3PM-11PM shift. A Braden Scale (assessment tool) dated 04/09/26 documented that the resident had a pressure sore risk score of 14, indicating that the resident was at moderate risk for developing a pressure ulcer. Care plans dated 04/09/26 documented in part, Problem-[Resident's name] needs assistance with daily ADL care related to recent hospitalization, difficulty in walking and other lack of coordination. Approaches (Intervention)- Bed Mobility- I need extensive assistance with 1 person staff support. Bathing- I need extensive assistance with 1 person staff support. I prefer a bed bath. Problem-[Resident's name] has altered elimination to incontinence of bowel and bladder. Approaches (Intervention)-Provide toileting assistance every shift, assess and report signs of impaired skin integrity or breakdown. Problem –[Resident's name] is at risk for pressure ulcers and other skin-related injuries.Approaches (Intervention)- Braden scale to be completed, observe skin for redness and breakdown during routine care, use pressure relieving devices, cushion on the wheelchair., follow (continued on next page)

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	06/16/2026

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

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F 0686 Level of Harm - Actual harm Residents Affected - Some	community skin care protocol, treatment as indicated.pressure reducing mattress. A history and physical dated 04/10/26 documented in part, This is a [AGE] year-old female with complex medical history. Diagnoses: Stage 1 Pressure Ulcer in Sacral Region. Plan-offloading protocol, barrier cream, wound consult nurse, reposition every 2 hours. A physician order dated 04/10/26 instructed, Weekly skin check by a licensed nurse on Tuesday 3 PM to 11 PM.for skin monitoring. A Braden Scale (assessment tool) dated 04/16/26 documented that the resident had a pressure sore risk score of 13 indicating that the resident was at moderate risk for developing a pressure ulcer. A document for certified nursing assistants titled, Daily Charting dated 04/21/26 documented in part, Description- bathing support provided, Time 3 PM - 11:30 PM, Status-One-person physical assist, Guidance-check resident skin for rashes, redness, wounds, bruises, if any problems noted, you must notify the nurse, Description-Does the resident have any skin problems? No, Name of nurse notified- Not applicable A document for certified nursing assistants titled, Daily Charting dated 04/22/26 documented in part, Description- bathing support provided, Time – 7 AM -3:30 PM, Status-One-person physical assist, Guidance-check resident skin for rashes, redness, wounds, bruises, if any problems noted, you must notify the nurse, Description-Does the resident have any skin problems? No, Name of nurse notified- Not applicable. An April 2026 Treatment Administration Record revealed that nurses signed their initials for 10 AM on 04/21 and 04/22, indicating that they provided wound care for the resident's sacral wound on those dates. A Situation, Background, Appearance, Review document dated 04/22/26 at 5:30 PM documented in part, Skin evaluation – no changes observed. A Skin Evaluation Form dated 04/23/26 at 7:25 PM documented in part, Left Buttocks DTI (Deep Tissue Injury) unstageable 30% skin, 20% slough, 50% dermis. Treatment-Cleanse with normal saline, pat dry, apply sliver alginate, [and] cover with optifoam. Occurred where-[NAME] Manor Nursing and Rehab Center [Ascension Health]. Size: length 8.0 cm, width 2.0 cm, depth not applicable. It should be noted that the facility's staff reclassified the resident's left buttock's DTI to an unstageable pressure ulcer when it opened on 04/23/26. Also, review of the resident's medical record lacked documented evidence of the resident's left buttock wound before the above-listed skin evaluation dated 04/23/26 at 7:25 PM. A Specialty Physician Initial Wound Evaluation & Management Summary dated 04/23/26 at 8:39 PM documented in part, Unstageable (Due to Necrosis) of the left buttocks full thickness, pressure, unstageable necrosis, noted to present on admission per staff, wound size length-8cm (centimeters) X width – 2 cm X depth – not measurable, exudate – moderate serous, slough – 20%, other variable tissue – 50%(Dermis).Procedure Notes- The wound was cleansed.then with clean surgical technique, 15 blade was used to surgically excise(to surgically remove).devitalized(dead) tissue. During a wound care observation provided by Employee #15 (LPN/Wound Care Nurse) starting at (continued on next page)

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	06/16/2026

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

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F 0686 Level of Harm - Actual harm Residents Affected - Some	10:57 AM on 05/22/26, the dressing removed from the left buttocks pressure ulcer had a moderate amount dark color drainage, no smell was noted, size was approximately the size of a quarter, wound bed covered with dark and yellow tissue, and no redness, swelling, or maceration was noted on the periwound. During a face-to-face interview at approximately 12 PM on 05/22/26, Employee #15 stated that she was recently returning from vacation for a month. She said that she was on vacation when the resident was admitted and when the resident's wounds were discovered by staff. Additionally, the employee reviewed the resident's wound care notes and stated that, according to the notes, the resident's left buttocks unstageable pressure was first observed by staff on 04/23/26. During a telephone interview starting at 12:13 PM on 05/27/26, Employee #14 (Wound Care Physician) stated that 04/23/26 was the first time he assessed the resident's wounds. The physician stated that the facility staff informed him that the resident was admitted with three wounds (post-surgical back wound, unstageable sacral pressure ulcer, and left buttocks pressure ulcer). The physician said that during his visit, he debrided both unstageable pressure ulcers. During a face-to-face interview at 10:13 AM on 05/29/26, Employee #12 [RN] stated that she and Employee #13 (RN) admitted Resident #150 to the facility on [DATE]. The employee said that when the resident was admitted , her skin in the sacral and groin area was dry, red, and intact. Additionally, the resident had a surgical wound on her back with intact staples. During a face-to-face interview at approximately 11:45 AM on 05/29/26, Employee # 13 (RN) stated that the resident was admitted to the facility without any open areas. The employee said that she documented in error that the resident had a Stage 2 sacral[pressure]ulcer on the Skin Evaluation form dated 04/09/26. Additionally, the employee stated that she observed the resident had a Stage 1 (pressure injury) area of redness in her sacral area. During a face-to-face interview at approximately 3:30 PM on 05/29/26, Employee #2 (DON) stated that staff did not make her aware of the resident's left buttocks unstageable wound. The employee stated it is the protocol that staff make her aware of wounds because they will determine if they do a root cause analysis of the wound. 2. Review of Resident #87 admission Progress notes created 4/11/2026 16:36 show Resident #87 was admitted [DATE] to the unit from home via private transportation. Resident alert and oriented to self and person, disoriented to time and place, consistent with history of dementia, no acute distress noted upon arrival. Comprehensive head to toe assessment completed. Skin assessment performed, skin noted to be intact. No pressure injuries noted on admission. Resident ambulates with assistance, gait observe to be unsteady . Nurse Practitioner assessment note included in part: created 04/11/2026 at17:22 showed admitted from home with diagnoses include Diabetes Mellitus type 2 Hypertension [AGE] years old female .Head to toe skin assessment was done, no open areas noted, resident noted with pink scar tissue on the coccyx areas, multiple strikes scars to the bilateral lower extremities and pink scar tissue on the right lateral ankle area. Resident has short thick and brittle toe nails. Care Plan dated 4/11/2026 showed Category16 Pressure Ulcers/Prevention: (Resident #87 is at risk Risk for pressure ulcers and other skin related injuries will maintain skin integrity without new skin related injuries over the next few. Next review period of rating scale to be completed key bed linens (continued on next page)

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	06/16/2026

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Ascension Living Carroll Manor	725 Buchanan St., NE Washington, DC 20017

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F 0686 Level of Harm - Actual harm Residents Affected - Some	wrinkle free and do not use excess pads observe skin for redness and break down during routine care use pressure relieving devices cushion on wheelchair and of of ears as indicated follow community skin care protocol treatments as indicated seized physicians order sheet pressure reducing mattress on bed OK admitted to the unit from home . comprehensive head to toe assessment completed. Skin assessment performed. Skin noted to be intact. No pressure injuries noted on admission. Careplan dated 4/13/26 showed Category 6 Incontinence: altered elimination due to incontinence of bowel and bladder: Skin will remain clean, dry and free of breakdown related to incontinence: need perineal cleansing and apply protective skin barrier after each incontinent episode, provide adult incontinent products and monitor for incontinence: assess and report signs of impaired skin integrity or break down. Nursing Progress Note created 4/27/26 10:42AM showed [Resident #87] is alert, breakfast served, appetite good consume 100% fluid intake 240cc, shower provide skin intact up in wheelchair. participate unit activities at living room drawing picture and socialized with other resident vital signs are T 97.2, R18, P90, BP145/81, sat 98 no abnormal behavior noted. Nursing Progress Note created 4/28/26 2:51PM showed Change in Condition: [Resident #87] alert during the ADL (activity of daily) care provided, resident observed with sacrum opening, this writer made aware nurse notify measure 0.2cm x 0.3cm no drainage. NP made aware new order zinc oxide twice a day cover with dressing, wound consult, family representative (name) notified. Careplan dated 4/29/2026 Category16 showed Risk for pressure ulcers and other skin related injuries, maintain skin integrity without new skin related injuries, (Resident #87) has an open area on the sacrum r/t (related to) limited mobility and incontinence; sacral wound will resolve without complication by the next review dates. Provide treatment as ordered, Monitor for pain and s/s of infection and notify MD (medical doctor), Continue all other interventions for skin care. Progress Note dated 4/29/2026 2:43PM showed Nutrition Note: RD (registered dietitian) notified of sacral skin opening (0.2 cm x 0.3 cm per nursing note). Continues on regular diet, thin liquids with usual meal intake of 75-100% per nursing notes. Current intake is adequate to meet estimated needs. No nutrition interventions at this time. RD will continue to follow PRN and alter nutrition interventions as needed. Wound Evaluation and management Summary dated 4/30/2026 showed At the request of the referring Dr. [Doctor named] a thorough wound care assessment and evaluation was performed today Focus room exam Stage 3 pressure wound sacrum full thickness etiology and quality pressure stage 3 duration less than one day objective healing maintain healing earning potential is fair estimated time to heal is fair care goes this month prevent infection decrease wound area manage exudation approach close monitoring education and counseling offloading additional wounds detail and avoided unavoidable pressure wound all preventive measures in place dressing treatment plan primary dressing is alginate calcium with silver apply once daily and as needed if saturated soil or dislodged for 30 days secondary dressing is gauze island with BDR apply once daily and as needed if saturated soil or this large for 30 days. Wound treatment is zinc ointment 20% apply Q shift three times a day and that's needed it's saturated soil or dislodged for 30 days Medication Flow sheet showed the dates with the type of wound treatments provided follows: (continued on next page)

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	06/16/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Start date 4/28/26 – End date 5/1/26 Desitin Daily Defense (zinc Oxide) apply topically two for opening sacrum time twice a day Continue 5/02/26 – open end date apply topically every shift to periwound on sacrum for skin care Treatments flow sheet showed the dates with the type of wound treatments provided follows: Start date 5/8/26 – End date 5/14/26 Alginate Calcium, Cleanse sacrum wound with NS, pat dry, and apply alginate calcium w/silver, then cover with Optifoam dressing once a day (7AM -3PM). Start date 5/15/26 – End date 5/15/26 Medihoney /Alginate Calcium, Cleanse sacral wound with NS,, pat dry, and apply medihoney alginate calcium w/silver, then cover with Optifoam dressing once a day (7AM -3PM). Start date 5/16/26 – Open end: Alginate Calcium, Cleanse sacrum wound with NS, pat dry, and apply alginate calcium w/silver, then cover with Optifoam dressing once a day (7AM -3PM). 5/22/2026 1:52pm Weight/wound note: Resident is triggering for sig weight gain of +9.7 lbs (7.5%) within 1 month following reweight .RD noted weight variance (lbs), (5/22) 137.5, (5/13): 141.8, (5/5): 139.4, (5/2): 129, (5/2): 142.1, (4/30): 128, (4/11 -admission): 127.8. No weight history/UBW on admission paperwork. BMI is 26.9, overweight, however within ideal range for age. Resident continues on regular diet (seafood allergy) with usual intake of 51-75% of meals. Resident with Stage 3 sacral PI [pressure injury]. Recommend addition of 30 mL liquid protein to support wound healing. Recommend monitoring weekly weights x3 weeks. RD will continue to follow. Observation made on 6/1/26 10:50 during wound care, the Sacrum wound, size of 0.8x0.4, has pink edges, no drainage and small amount of yellow (slough) in the middle. Interview was conducted on 6/1/26 10:53AM with the wound nurse. She stated Resident had no wound on admission, wound was found 4/29/26, Stage #3 wound, the measurement on Thursday was 0.8x0.4, daily dressing change completed, treatment is Alginate silver and cover with Opti form pads. Wound healing is in progress. Interview on 6/1/26 10:56 concerning comfort level with Resident#87, she denies pain at wound site. Told surveyor it was ok to come in and see the wound /wound care. A interview with the Director of nursing was conducted on 6/15/2026 at 3pm concerning the initial observation of Resident#87's altered skin at an advanced stage (sacrum wound initially identified at Stage #3).

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	06/16/2026

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, it was determined that the facility staff failed to wash and sanitize chinaware plates and silverware properly; and failed to ensure that supplements were not stored beyond the 'use by' date for for 17 of 24 Ensure supplements observed expired. The findings included: 1. During an observation of the dishwashing process in the main kitchen at approximately 4 PM on 06/15/26, it was revealed that six (6) of 21 chinaware plates, three (3) of 3 forks, three (3) of 25 spoons, and one (1) of 10 knives were not properly sanitized as evidenced by food particles remaining on the eating surface of the previously mentioned chinaware plates and eating utensils after they had been washed and sanitized. During a face-to-face interview at approximately 4:30 PM on 06/15/28, Employee #11 (Dietary Manager) stated that the staff would rewash and sanitize the plates and eating utensils. 2. During an observation conducted on 05/28/26 at approximately 12:40 PM of the Second-Floor medication storage room, it revealed an opened case of Ensure supplement drinks with a use by date of 05/01/2026 and only 17 of 24 – eight (8) fluid ounce supplement drinks remaining. It should be noted that seven (7) – eight (8) fluid ounce supplement drinks were unaccounted for. During a face-to-face interview conducted on 05/28/26 at approximately 12:45 PM with Employee #5 (Registered Nurse, Unit Manager), she acknowledged the findings.

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	06/16/2026

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

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, for one (1) of 53 sampled residents, the facility staff failed to evaluate a Resident for occupational therapy services per the physician's order. Residents #146.The findings included: Resident #146 was admitted to the facility on [DATE] with diagnoses that included: Unspecified Dementia, Chronic Kidney Disease Stage 4, Chronic Embolism and Thrombosis, Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, and Retention of Urine, Localized Edema, and Unsteadiness on Feet. On 05/13/26, the State agency and the facility received a Complaint (3012416) via email from Resident #146's family member and the Resident's legal guardian, which documented in part: Since May 4th, my mother has made multiple requests for a return call from the [Name of Facility's Medical Team] .our request to speak directly with a physician or nurse practitioner has gone unanswered . An email response to the State agency dated 05/15/26 from the Facility's Administrator documented: .Please see updates below in reference to concerns listed above.DON (Director of Nursing) met with daughter.Spoke with NP who will have the attending see the resident on Friday, May 15th. Order placed and communicated with therapy for OT to eval [evaluate] entry for ability to feed herself. Family was able to speak with the NP. A review of Resident #146's medical record revealed: A quarterly Minimum Data Set (MDS) assessment dated [DATE] that documented that Resident #146: had a Brief Interview for Mental Status (BIMS) summary score of, 3, indicating that the resident had severely impaired cognition; required maximal assistance to from facility staff for eating, oral hygiene, upper body dressing, and applying footwear; was dependent on facility staff for toileting, bathing, and personal hygiene; had an indwelling urinary catheter; was frequently incontinent for bowel movements, and had received an anticoagulant within the past seven days of the assessment.A physician's order dated 05/14/26 that directed: OT (Occupational Therapy) to eval (evaluate) for decreased ability to feed self once a day, prn (as needed). A nursing progress note dated 05/18/2026 at 12:09 PM that documented: Writer received a call and an Email from [Resident #146's Legal Guardian] requesting an in-person family care meeting on 05/14/26 with the current attending physician, Nurse Practitioner, Clinical Nursing Leader for the fourth floor, and assigned social worker. The meeting was held on 5/14/26 per [Resident #146's Legal Guardian]'s request. concerns included lack of communication with the medical team, resident's ability to feed herself.order was placed for OT to evaluate and treat resident for ability to feed herself, and resident. Further review of Resident #146's medical record showed no documented evidence that occupational therapy evaluated Resident #146's ability to feed herself after conducting the family meeting held on 05/14/26, and per the physician's order on 05/14/26. During a face-to-face interview on 05/29/2026 at 10:34 AM, Employee #1 (Administrator) stated that she had a paper trail to show that the legal guardian's concerns for Resident 3146 were addressed. She added that the NP (Nurse Practitioner) and OT (Occupational Therapy) met with the family. During a face-to-face interview with Employee #2 (Director of Nursing/DON) stated that she sent the following email to OT on 05-14-26 at 2:30 PM: Good Afternoon, Please have OT evaluate her period. Apparently, she can feed herself on some days and on other days she cannot. On 04-14-26 at 2:57 PM. Employee #24 (Director of Rehabilitation Services) sent the following email correspondence to Employee #2 /DON: Ok, no problem. We'll start the process tomorrow. During a face-to-face interview on 6/15/26 at 4:22 PM, Employee #24 stated, The Resident was on my list of residents to be evaluated for OT on 5/23/26. I had to prioritize that list with new admissions always first to be evaluated. Resident #146 got pushed down on the list. I did not let her family, the Administrator, or the DON know that. The Employee then acknowledged the finding.

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	095034	A. Building B. Wing	06/16/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and interview, for two (2) of 53 sampled residents, the facility staff failed to ensure: (1) Resident #150's record contained accurate documentation related to the staging of her wound. (2) Resident #179's record contained accurate documentation of skin sheets. (Residents #150 and #179)The findings included: 1. Resident #150 was admitted to the facility on [DATE] with multiple diagnoses including Fracture of First Lumbar Vertebra, Abnormalities of Gait Mobility, Generalized Muscle Weakness, Severe Protein-Calorie Malnutrition, and Need for Assistance with Personal Care.The policy Procedure: Pressure Injury Assessment/Treatment with a review date of 01/26 documented in part, There are four stages of pressure injury.Stage 1 -skin remains intact at this stage. Intact skin with a localized area of non-bleachable erythema.Stage 2-partial thickness loss of skin with exposed dermis. The wound bed is pink or red, moist.An admission nursing progress note dated 04/09/26 at 6:06 PM documented in part, Resident is alert, oriented and verbally responsive. Skin is warm to touch, redness and dryness noted towards perineal, right groin and sacral area. A skin evaluation form dated 04/09/26 at 10:55 PM documented in part, Sacral Ulcer with redness/Moisture Acquired Skin Damage. Treatment: Cleanse the sacral area with normal saline; apply Z-Guard after incontinent care. Occurred where - [local hospital's name]. Stage-2.During a face-to-face interview at 11:45 AM on 05/29/26, Employee #13 (RN) stated that she was one of the nurses who admitted the resident on 04/09/26. The employee said that she documented in error that the resident had a Stage 2 sacral pressure ulcer. Additionally, the employee stated that on admission [DATE]) the resident had a Stage 1 sacral injury. The skin was red with no open areas. 2. Resident #179 was admitted to the facility on [DATE] with multiple diagnoses including Dementia, Acute Respiratory Distress, and Need for Assistance with Personal Care.A State Survey Agency Complaint Intake #2732976 dated 01/30/26 documented in part, In August 2024, Ms. [NAME] reports that a letter was submitted to the facility regarding a bedsore. The bedsore reportedly remained present, caused discomfort, and the resident was not receiving adequate assistance. During a review of the resident's medical record on 05/29/26 at approximately 11 AM, the record lacked documented evidence of shower sheets for August 2024. At the time of the record review, Employee #23 (Unit Manager/RN) stated that she would check for the records in the filing closet. The employee also stated that the facility's protocol requires the nurse and CNA to observe the resident's skin from head to toe for skin integrity issues/concerns and document the findings on the CNA Bath and Shower Documentation Sheet. At approximately 1 PM on 05/29/26, Employee #26 (RN) provided the surveyor with CNA Bath and Shower Documentation Sheets dated 08/14/24, 08/17/24, 08/21/24, 08/24/24, 08/28/24, and 08/31/24. Review of the shower sheets revealed the staff did not document any concerns with Resident #179's skin. The employee stated that she could not find the original shower sheets, so she looked at the staff schedule for those days and had staff who worked to re-create them. The employee said that she could not verify if the information documented about Resident #179's skin assessment was accurate because she did not work for the facility during that time. During a face-to-face interview at approximately 1:30 PM, Employee #27 (CNA) who signed her name on the shower sheets for 08/14/26, 08/17/26, 08/21/26, 08/28/26, and 08/31/26 stated that she was asked to complete the sheets today (05/29/26). The employee said that she could not verify if the information was accurate. During a face-to-face interview at approximately 2 PM on 05/29/26, Employee #2 stated that the employees should not have re-created the shower sheets.