. CENTE	RS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FOR	D: 12/21/2 M APPROV O. 0938-0
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTIO '} A BUILDING			(X3) DATE SURVEY COMPLETED		
	NAME OF PROVIDER OR SUPPLIER		B. WING	·	R		
	PROVIDER OR SUPPLIEF		5	2131 O S	DRESS, CIT", STATE. ZIP CODE TREET NVI IGTON, DC 20037	1 12	/20/2007
(X4) ID PREFIX YAG	LEACH DEFICIENT	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	1 (	PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SHOOSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLE DAYE
(F 000)	October 26, 2007)	(to the recertification survey on was conducted December 20	{F 000	0}		2001 JAN	DEPARTM HE ALTH
(F 279)	record review, observed the sample size work of the standard surand two (2) supple	ng deficiencies were based on ervations and staff interviews. Vas 16 records based on 60% Vey sample for 178 residents				-9 A II:	REGULATION
SS=D	A facility must use	the results of the assessment and revise the resident's	{F 279	1a. 1b.	Resident F1 was not h by the deficient pract  A care plan was initia	ice.	
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable stables to meet a resident's and mental and psychosocial			12/20/07 for resident l address the significan weight loss.	F1 to t	
	assessment. The care plan must to be furnished to a highest practicable	describe the services that are train or maintain the resident's physical, mental, and		] Jc.	The attending physici reviewed the resident' of care for weight loss lasix was discontinued 12/20/07.	s plan and	•
	psychosocial well-b §483.25; and any so be required under § due to the resident's	eing as required under arvices that would otherwise 483.25 but are not provided sexercise of rights under the right to refuse treatment		1d.	Dietary Supplement wincreased 12/21/07 and weights are monitored weekly for 12 weeks.	d	
	by: Based on staff intendence (1) of 18 sample Determined that facil	IT is not met as evidenced view and record review for ed residents, it was ity staff falled to initiate a and applicables to address		2,	All other resident charwith significant weigh were reviewed for care and were found to be a compliance.	t loss e plans	

Any deficiency statement ending with an asterisk of denotes a deficiency which the institution may be excusted 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

Ø 004/011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER		095031 B.1		IPLE CONSTRUCTION		
ROCK	CREEK MANOR NURS	SING CTR	2	REET ADDRESS, CIT (, STATE, 2 2131 O STREET NW WASHINGTON, DID 20037	IP CODE	
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DÉFÍCIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH COR RECTIVE AI CROSS-REFE RENCED TO DEFICIENT	CTION SHOULD BE THE APPROPRIATE	COMPLETION DATE
{F 492} S\$=D	The findings includ The Monthly weight November 3, 2007 December 3, 2007 December 5, 2007 A review of the Nut. Assessment/Progree 2007 revealed, "Assessment/Progree [2007] wt foss isn't of greater than IBW [infurther wt foss. Plant Recommendations: hydration. Diet shall prevent further weight weeks to closely in the recommendation of the recommendation of the recommendation of the record was initiated to addree the record was reviewed	t record revealed the following: weight=166,7 weight=158 weight =159 rition Quarterly as Note dated December 3, sessment: Feeder, eats fair to Significant wt [weight] loss x at had edema in October desired at this rate. Wt is deal body weight]. Goal: No n: f/u [follow up] PRN. Encourage food intake for ke 4 oz BID [twice a day] to that loss. Weekly wts x 4 nonitor wts."  rd lacked evidence that a ed with goals and approaches is F1's weight loss. liew was conducted with cember 20, 2007 at 12:25 viedged that a care plan was ass the resident's weight loss. lewed on December 20, 2007.	{F 279}	3a. The MDS Coore-in-service a interdisciplina members on the development of for significant 1/11/08.  3b. The dietician weight ensure the development weight ensure the development weight loss and will be reported dietician for impremedial action problems will be in the monthly I Management/Q, and Quarterly Q. Assurance Meet remedial action.	ry team re f care plans weight loss by  vill review ts monthly to elopment of any ght changes.  ing to resident care plans to the mediate Continued e discussed Risk A Meeting Quality ing for	1/11/08

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 12/21/2007 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LDING.	(X3) DATE SURVEY COMPLETED			
		095031	B. WIN	IG		12/	R 20/2007
	PROVIDER OR SUPPLIER			2131 O STI	RESS, CITY, STATE, ZIP CODE REET NA STON, D. 20037	, 121	2012007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	X ' (E.	PROVIDER'S PLAN OF CORRECTOR SHOPS SEREFER ENCED TO THE APPROPRIES.	LILD BE	COMPLETION DATE
(F 492)	Continued From page	ge 2	{F 49	92)			!
	by: Based on observation determined that fact expired medication was medication cart and two (2) of five (5) nutemperatures were to the findings include			1a. 1b.	Resident W-7 was not harmed by the deficient practice.  The expired medication removed from the medication cart and discarded immediately 12/20/07.	nt n was	
i	Facility staff falled medication from the      DCMR (District of Regulation) 3227.12 expired medication susage".	medication cart		2a.	All medication carts an medication refrigerator were checked for expiral medications and found in compliance.	rs ed	
	tablets of Bisacodyl S with an expiration day observed in the media The tablets were sho time of the observation that the medication was A review of the reside Bisacodyl was discon	wn to Employee #1 at the on. He/She acknowledged as expired.  Int's record revealed that three three was no evidence that the		3a. 3b.	Licensed staff will be reinserviced by 01/10/08 of process of identification disposal of expired medications.  RCCs (Resident Care Coordinator, Superviso and Charge nurses will monitor medication car and medication refriger daily for expired medications.	on the and rs	
2	<ol> <li>Facility staff failed nedication from the n</li> </ol>	to remove expired nedication refrigerator.		3c.	RCCs will ensure compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R 12/20/2007	
	095031		8, WING			
	ROVIDER OR SUPPLIEF		2131	T ADDRESS, CIT'', STATE. ZIP CODE I O STREET NW SHINGTON, D.D. 20037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDE 'S PLAN OF CORRE (EACH COR 'ECTIVE ACTION SH CROSS-REFE' ENCED TO THE API DEFICIENCY)	HOULD BE	COMPLÉTION DATÉ
{F 492}	Continued From p	page 2	{F 492}			
	by: Based on observation determined that far expired medication medication cart at two (2) of five (5)	ENT is not met as evidenced ations and staff interviews, it was acility staff failed to ensure that in was removed from the and medication refrigerator for nursing units and that cold food a below 41 degrees Fahrenheit.		Problems relating to exmedications will be disting the Monthly Risk Management/QA meet and Quarterly Quality Assurance meeting for remedial action.	cussed	1/10/08
	The findings Inclu	de:		•		
;		iled to remove expired he medication cart	1			
	Regulation) 3227.	t of Columbia Municipal 12 reads as follows: "Each n shall be removed from				
:	tablets of Bisacod with an expiration	2007 at 6:55 AM, two (2) yl 5 mg labeled for Resident W7 date of September 2007 were edication cart on Unit 1.	!			
;		shown to Employee #1 at the ation. He/She acknowledged n was expired.				
	Bisacodyl was disc August 7, 2007. T	sident's record revealed that continued by the physician on here was no evidence that the the medication since the te.				
		led to remove expired ee medication refrigerator.				

		H AND HUMAN SERVICES E & MEDICAID SERVICES			FOR	D: 12/21/2007 M APPROVED D. 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	DITIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
	095031  AME OF PROVIDER OR SUPPLIER		B, WINC	· · · · · · · · · · · · · · · · · · ·	12	R /20/2007
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CIT', STATE, ZIP COI	DE	
ROCK	REEK MANOR NURS			2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDE I'S PLAN OF COR (EACH COR RECTIVE ACTION CROSS-REFEI ENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION . DAYE
	Tuberculin Purified expiration date of Nincluded] was obserefrigerator on Unit opened was documented label.  A face-to-face interemployee #2 at the He/She stated that after the open date 2007.  A face-to-face interemployee #2 at 10 two (2) residents, Receiving the Tuber 10, 2007.  A review of the hurs and F2 revealed that adverse reactions for the records were reactions.  B. On December 20 AM, a vial of Tubercords with an experience of the property and the records were reactions.	0, 2007 at 7:40 AM, a vial of Protein Derivative with an November 2 [there was no year reved in the medication 3. The date that the vial was nented as October 2, 2007 on view was conducted with time of the observation. the vial was good for 30 days, which would be November 2, view was conducted with 30 AM and he/she identified esidents F1 and F2 as culin injection on December ses notes for Residents F1 at the residents had no rom the Tuberculin injection.	{F 49:	1a. Resident F1 and F2 harmed by the defic practice.  1b. Tuberculin purified vial was discarded immediately on 12/2  1c. The PPD for resident F2 were redone on 1 with normal skin test medication refrigerately checked for expired medication and foun in compliance.  3a. Licensed staff will be serviced by 01/10/08 process of identificated disposal of expired medications.  3b. RCCs, Supervisors a Charge nurses will medication carts and	protein 20/07.  t F1 and 2/22/07 t.  and tors were d to be cre-in- on the ion and	
	Employee #4 at the He/She acknowledgexplred. There were no resident	ilew was conducted with time of the observation. ed that the Tuberculin was ents identified to have in injection on Unit 4.		medication refrigera for expired medication  3c. RCCs will ensure compliance.		

PRINTED: 12/21/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING B. WING 095031 12/20/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CIT', STATE, ZIP CODE 2131 O STREET NW **ROCK CREEK MANOR NURSING CTR** WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDE I'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH COR RECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPERIENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) (F 492). Continued From page 3 (F 492) A. On December 20, 2007 at 7:40 AM, a vial of Tuberculin Purified Protein Derivative with an Problems relating to expired 4. expiration date of November 2 [there was no year medications will be included] was observed in the medication discussed in the Monthly refrigerator on Unit 3. The date that the vial was opened was documented as October 2, 2007 on Risk Management/OA the label. meeting and Ouarterly 1/10/08 Quality Assurance meeting. A face-to-face interview was conducted with Employee #2 at the time of the observation. He/She stated that the vial was good for 30 days after the open date, which would be November 2. 2007. A face-to-face interview was conducted with Employee #2 at 10:30 AM and he/she identified two (2) residents, Residents F1 and F2 as receiving the Tuberculin injection on December 10, 2007. A review of the nurses notes for Residents F1 and F2 revealed that the residents had no adverse reactions from the Tuberculin injection. The records were reviewed on December 20. 2007 B. On December 20, 2007 at approximately 8:10 AM, a vial of Tuberculin Purified Protein Derivative with an expiration date of November 7. 2007 was observed in the medication refrigerator on Unit 4. A face-to-face interview was conducted with Employee #4 at the time of the observation. He/She acknowledged that the Tuberculin was expired. There were no residents Identified to have

received a Tuberculin injection on Unit 4.

PRINTED: 12/21/2007

		H AND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 12/21/2007 M:APPROVED D: 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	DING	(X3) DATE SURVEY COMPLETED			
		095031	B. WING	3		12/	R 20/2007
	ROVIDER OR SUPPLIER			2131 O STI	RESS, CIT', STATE, ZIP CODE REET NW GTON, D. 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFICIENCIES CY MUST BE PRECÉDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDE I'S PLAN OF CORREC ACH COR RECTIVE ACTION SHO DSS-REPEILENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
AT	A. On December 2 Tuberculin Purified expiration date of included] was obsirefrigerator on Unit opened was docur the label.  A face-to-face inte Employee #2 at the He/She stated that after the open date 2007.  A face-to-face inte Employee #2 at 10 two (2) residents, Freceiving the Tuber 10, 2007.  A review of the nurand F2 revealed the adverse reactions of The records were records.  B. On December 2007.  B. On December 2007.  B. On December 2007.  And, a vial of Tuber 2007 was observed on Unit 4.  A face-to-face interemployee #4 at the	age 3 20, 2007 at 7:40 AM, a vial of d Protein Derivative with an November 2 [there was no year erved in the medication it 3. The date that the vial was mented as October 2, 2007 on rview was conducted with e time of the observation. If the vial was good for 30 days is, which would be November 2, rview was conducted with it 30 AM and he/she identified Residents F1 and F2 as roulin injection on December ses notes for Residents F1 at the residents had no from the Tuberculin injection. The reviewed on December 20, 2007 at approximately 8:10 culin Purified Protein explration date of November 7, if in the medication refrigerator view was conducted with time of the observation, ged that the Tuberculin was	{F 49	2) 1a. 1b. 2a. 3a. 3b. 3c. 4.	No resident was harmed unit 4 by the deficient practice.  The Tuberculin Purific Protein vial was discar immediately on 12/20/6  All medication carts as medication refrigerator checked for expired medications and found in compliance.  Licensed staff will be reinserviced on 01/10/08 process of identification disposal of expired medications.  RCCs, Supervisors and Charge nurses will more medication carts and medication refrigerator for expired medications.  RCCs will ensure compute Problems relating to expect medications will be discing the Monthly Risk Management/QA meeting and Quarterly Quality Assurance meeting for	ed ded of.	
		dents identified to have lin injection on Unit 4.			further remedial action		1/10/08

TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095031		(X2) MU A. BUILI	ELTIPLE CONSTRUCTION	OMB NO. 0938-0: (X3) DATE SURVEY COMPLETED	
		B. WING		12	R 20/2007
CK CREEK MANOR NURS			STREET ADDRESS, CIP'. STATE, ZIP CODI 2131 O STREET NW. WASHINGTON, DID 20037	E .	201200#
REGULATORY ON I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDE I'S PLAN OF CORR (EACH CORI:ECTIVE ACTION S CROSS-REFEITENCED TO THE AP DEFICIENCY)	HOHIOAR	COMPLETION DATE
(92) Continued From pa	ige 4	(F 492	9);		<u> </u>
Pahrenheit (F) at the resident.  22 DCMR 3220.2 restemperature for cold forty-one degrees F delivery to the reside.  On December 20, 20 breakfast test tray lestemperatures were to passed and all reside.  2% Milk 54 F. Apple Juice 62.8 F. Temperatures of the presence of Employer testing the food, Employer testing the food, Employer the food temperature. He/she stated, "Cold	e point of delivery to the e point of delivery to the eads as follows: "The foods shall not exceed ahrenheit at the point of ent".  207, it was observed that the fit the klichen at 9:03 AM, 19:04 AM. Food ested after the last tray was ents were eating at 9:25 AM:  food were tested in the left. Upon completion of loyee #1 was asked what s should be when served, foods should be below 40 and hot foods about 140.		1a. No resident was harm the deficient practice.  1b. The 2% milk and app whose temperature was discarded.  2a. All other cartons of milces were checked an found to be in refriger with temperature belon degrees Fahrenheit.  3a. All dictary staff and mistaff were re-in-service 12/24/07 on how to main beverage temperature degree Fahrenheit or b  3b. Cartons of milk and juic carried on ice to the unimaintain the temperature below 41 degrees fahren degree fahren degree fahren degree fahren degree fahren degree fahren degrees fahr	ele juice erc enheit  ilk and nd ation w 41  ursing ed on intain at 40 elow. ices are its to ure uheit.	

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FOR	D: 12/21/200 MAPPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		CONSTRUCTION;	OMB NO. 0938-03: (X3) DATE SURVEY COMPLETED		
		095031	B. WING			121	R
	PROVIDER OR SUPPLIER REEK MANOR NURSI	NG CTR	S	2131	ADDRESS, CIT'. STATE. ZIP CODE O STREET NW HINGTON, D.: 20037	} 12/	20/2007
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	PROVIDE I'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	HDAC	(X5) COMPLETION
(F 492)	Continued From page	je 4	{F 492	2};			
	ranrenneit (F) at the resident.  22 DCMR 3220.2 re temperature for cold forty-one degrees Fadelivery to the reside On December 20, 20 breakfast test tray learnived on the unit at temperatures were to passed and all reside 2% Milk 54 F. Apple Juice 62.8 F. Temperatures of the presence of Employed testing the food, Empley the food temperatures de/she stated, "Cold	d foods below 41 degrees point of delivery to the ads as follows: "The foods shall not exceed threnheit at the point of int".  107, it was observed that the fit the kitchen at 9:03 AM, 9:04 AM. Food ested after the last tray was ents were eating at 9:25 AM:  108 food were tested in the e #1. Upon completion of loyee #1 was asked what is should be when served.  109 foods should be below 40 and hot foods above 140		4.	Problems relating to food beverage temperature wi reported to the Director of Food services for immediatemedial action. Continuproblems will be discusse the monthly Risk Management/QA meeting Quarterly Quality Assurameeting for remedial actions.	II be of ate ed d in g and	12/24/07
			:			 	