PRINTED: 02/07/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES Per occupied 2/24/00 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 DEPARTME B WING 095031 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131-O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 An annual recertification survey was conducted on January 17 through 20, 2006. The following deficiencies were based on record review. observations and interviews with staff and residents. The sample included 25 residents based on a census of 165 residents on the first day of survey and one (1) supplemental resident. 1a. Resident M1 is no longer exposed during F 241 F 241 483.15(a) DIGNITY bed bath. SS=D The facility must promote care for residents in a 2. All residents receiving manner and in an environment that maintains or bed bath were checked to enhances each resident's dignity and respect in full recognition of his or her individuality. make sure they were not exposed and are well draped during bed bath This REQUIREMENT is not met as evidenced by 3a. RCCs/ Team Leaders will make Based on observation of one (1) of 25 residents, rounds during AM care to a CNA (Certified Nurse Aide) failed to maintain the dignity of Resident M1 while administering a make sure all residents are well bed bath. draped during AM care. The findings include: 3b. All CNA's will be in serviced On January 17, 2006 at approximately 9:30 AM on bed bath procedures. 2/28/06. the survey orientation tour was conducted on the first floor residents ' unit. Upon entering Resident M1's room, it was observed that the privacy 4. Problems relating to improper curtains were pulled around the bed. However. exposure of resident during bed further observation of the resident revealed that bath will be discussed in the resident was being bathed and was fully

OR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE LABORA DIRECT

maintain the resident's dignity while administering

The CNA (Certified Nurse Aide) failed to

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

monthly Risk Management/QA

meeting and quarterly QA

TITLE

min

meeting for remedial action.

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.

exposed.

3/6/06

(X6) DATE

PRINTED: 02/07/2006 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 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) F 241 Continued From page 1 F 241 a bed bath. The RCC (Resident Care Coordinator) was accompanying the survey during the tour and acknowledged that the resident was exposed. The CNA made no attempt to cover the resident. 483.15(h)(2) HOUSEKEEPING/MAINTENANCE F 253 F 253 SS=E The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled and stained privacy curtains, excessive telephone and cable wires on floors in ambulating areas. Geri chair armrests were torn and damaged, and housekeeping closets lacked racks for storing

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings include:

following residents rooms:

PM on January 17, 2006.

cleaning equipment off floor surfaces. These findings were observed in the presence of the Housekeeping and Maintenance Directors.

1. Privacy curtains were soiled and stained in the

First floor rooms 113,117, 120 and 130 in four (4) of 13 observations between 2:56 PM and 3:45

Event ID: QXXC11

Facility ID: ROCKCREEK

If continuation sheet Page 2 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2006 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 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG F 253 Continued From page 2 F 253 1a. Privacy curtains in rooms Second floor rooms 205, 207 and 215 in three (3) 113, 117, 120, 205, 215, 403, of 13 observations between 2:16 PM and 3:40 PM on January 18, 2006. 404, 413, 506, 517 were Cleaned, 1/25/06. Fourth floor rooms 403, 404 and 413 between 9: 11 AM and 11:40 AM in three (3) of seven (7) 1b. Room 207 is a private room observations on January 19, 2006. and never had privacy curtains. Fifth floor rooms 506 and 517 in two (2) of six (6) observations between 11:44 AM and 12:30 PM on 1c. Contract bids are taken to January 19, 2006. replace privacy curtains on floors 2, 4 and 5. 2. Excessive telephone cord and communication wires were observed on floors in ambulating areas of residents' rooms. 2. All privacy curtains have been checked and cleaned. First floor rooms 102 and 117 in two (2) of nine (9) observations between 3:56 and 4:00 PM on 3. All privacy curtains will be January 17, 2006. checked daily and during Fourth floor rooms 404 and 407 in two (2) of six (weekly Grand Rounds. 6) observations between 9:11 AM and 10:00 AM on January 19, 2006. 4. The Director of Environmental Services will submit reports Fifth floor room 517 in one (1) of six (6) observations between 11:44 AM and 12:30 AM on related to privacy curtains January 19, 2006. immediately to the Administrator and report will be given in the 3. Geri chairs armrest in residents' rooms and common areas were torn and damaged in the quarterly QA Meeting. 3/6/06 following areas: Second floor room 216 in one (1) of seven (7) observations at approximately 3:30 PM on January 18, 2006.

on January 19, 2006.

Third floor rooms 304 and 314 in two (2) of seven (7) observations between 4:45 PM and 5:30 PM

PRINTED: 02/07/2006 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 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 Continued From page 2 F 253 Second floor rooms 205, 207 and 215 in three (3) 1. Unsecured telephone cords of 13 observations between 2:16 PM and 3:40 in rooms 102, 117, 504, PM on January 18, 2006. and 520 were secured 1/18/06 Fourth floor rooms 403, 404 and 413 between 9: 11 AM and 11:40 AM in three (3) of seven (7) observations on January 19, 2006. 2. All telephone cords in residents' rooms were checked by the Fifth floor rooms 506 and 517 in two (2) of six (6) Director of Maintenance and observations between 11:44 AM and 12:30 PM on found to be in Compliance. January 19, 2006. 2. Excessive telephone cord and communication 3. The Director of Maintenance will wires were observed on floors in ambulating check telephone cords weekly areas of residents' rooms. during Grand Rounds and record them in the Maintenance First floor rooms 102 and 117 in two (2) of nine (9) observations between 3:56 and 4:00 PM on logbook to ensure compliance. January 17, 2006. 4. Problems related to telephone Fourth floor rooms 404 and 407 in two (2) of six (cords, will be reported 6) observations between 9:11 AM and 10:00 AM immediately to the on January 19, 2006. Director of Maintenance Fifth floor room 517 in one (1) of six (6) unto the Administrator for observations between 11:44 AM and 12:30 AM on remedial action and discuss January 19, 2006. in the quarterly QA meeting. 3/6/06 3. Geri chairs armrest in residents' rooms and common areas were torn and damaged in the following areas:

January 18, 2006.

on January 19, 2006.

Second floor room 216 in one (1) of seven (7) observations at approximately 3:30 PM on

Third floor rooms 304 and 314 in two (2) of seven (7) observations between 4:45 PM and 5:30 PM

		AND HUMAN SERVICES MEDICAID SERVICES			FORM): UZ/U//ZUU6 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095031		1	IULTIPLE CONSTRUCTION LDING	(X3) DATE S	SUŖVEY	
		B. WIN	4G	01/3	20/2006	
	NAME OF PROVIDER OR SUPPLIER ROCK CREEK MANOR NURSING CTR			STREET ADDRESS, CITY, STATE, ZIP COD 2131 O STREET NW WASHINGTON, DC 20037		20/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE CROSS-	(X5) COMPLETION DATE
f f S C J	Second floor rooms of 13 observations between January 19, 2006. Every floor rooms 102 observations between January 17, 2006. Every floor rooms 102 observations between January 17, 2006. Every floor rooms 102 observations between January 17, 2006. Fourth floor rooms 102 observations between January 17, 2006. Fourth floor rooms 406 observations between January 17, 2006. Fifth floor rooms 517 in observations between January 19, 2006. Gerichairs armrest common areas were tollowing areas: Second floor room 216 observations at approximations at approximation 18, 2006. Third floor rooms 304 of third floor rooms	205, 207 and 215 in three (3) retween 2:16 PM and 3:40 2006. 03, 404 and 413 between 9: If in three (3) of seven (7) uary 19, 2006. 5 and 517 in two (2) of six (6) in 11:44 AM and 12:30 PM on one cord and communication on floors in ambulating froms. and 117 in two (2) of nine (9 en 3:56 and 4:00 PM on one (1) of six (6) in 11:44 AM and 10:00 AM one (1) of six (6) in 11:44 AM and 12:30 AM on one (1) of seven (7)	F 2	1. Geri-chair armrest in 21 304, 344, 413, 506, 514 will be replaced. 2. All Geri-chairs were checked and found to be in compliance. 3a. Maintenance Aides will Monitor wheelchairs and Geri-chairs daily for compliance. 3b. Nursing Assistants will in-serviced to avoid misu of Geri-chairs when transporting residents. 4. Incidents of torn or worm Geri-chairs and wheelcha will be discussed in quarterly QA meeting and reported to the Administrator for repairs or replacement.	ce. d be use out	3/6/06

		& MEDICAID SERVICES					1 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 ² (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII			COMPLETED		
Control of the contro	095031		B. WIN	1G		0415	0/2006
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	01/2	20/2006
ROCK	CREEK MANOR NURSI	NG CTR		21	31 O STREET NW ASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG	3373	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETION DATE
	Second floor rooms of 13 observations is PM on January 18, 2 11 AM and 11:40 AM observations on January 19, 2006. 2. Excessive telephowires were observed areas of residents' rooms 102 observations between January 17, 2006. First floor rooms 102 observations between January 17, 2006. Fourth floor rooms 44 observations between January 19, 2006. Fifth floor rooms 517 in observations between January 19, 2006. Geri chairs armress common areas were following areas: Second floor rooms 21 observations at appropriate of the property 18, 2006. Third floor rooms 304	205, 207 and 215 in three (3) between 2:16 PM and 3:40 2006. 203, 404 and 413 between 9: If in three (3) of seven (7) uary 19, 2006. 3 and 517 in two (2) of six (6) and 11:44 AM and 12:30 PM on one cord and communication on floors in ambulating poms. and 117 in two (2) of nine (9 en 3:56 and 4:00 PM on one (1) of six (6) and 10:00 AM and 10:00 AM and 10:44 AM and 12:30 AM on the cord and damaged in the fin one (1) of seven (7) ximately 3:30 PM on and 314 in two (2) of seven and 314 in two (2) of seven and 314 in two (2) of seven	F 2		 Closet racks were installed in all janitor closets. 2/10/2 All housekeeping closets needing racks were checked were found to be in complite 2/10/06. All housekeeping closets will be checked during Grand Rounds for compliant regarding closet racks. The Director of Environment Services (DES) will submit reports related to problems closet racks immediately to Administrator and reports be presented in quarterly Qua	d and ance. nce ental at sof o the will	3/6/06
	Third floor rooms 304 (7) observations betwoon January 19, 2006.	and 314 in two (2) of seven een 4:45 PM and 5:30 PM					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/07/2006 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 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 253 Continued From page 3 F 253 Fourth floor room 413 in one (1) of eight (8) observations at approximately 9:15 PM on January 19, 2006. Fifth floor rooms 506, 514 and Social Room in three (3) of seven (7) observations between 11:44 AM and 12:30 PM on January 19, 2006. 4. Housekeeping closets lacked racks to store mops, brooms and dust pans away from floor surfaces. First Floor in (1) of five (5) observations at approximately 5:10 PM on January 17, 2006. Second Floor in one (1) of five (5) observations at approximately 3:30 PM on January, 2006. Third Floor in one (1) of five (5) observations at approximately 4:20 PM on January 18, 2006. Fourth Floor in one (1) of five (5) observations at 11:25 AM on January 19, 2006.

and plan of care.

F 309

SS=D

Fifth Floor in one (1) of five (5) observations at 12

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in

accordance with the comprehensive assessment

This REQUIREMENT is not met as evidenced by

:10 PM on January 19, 2006.

483.25 QUALITY OF CARE

F 309

02/23/2006 17:03 FAX 2023310857 ROCK CREEK MANOR Ø004/004 2/23/06 KINTED, UZJUTIZOOB DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095031 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG F 309 Continued From page 4 F 309 Based on observation, staff interview and the review of the clinical record for one (1) of 25 residents, it was determined that facility staff failed to reassess Resident #17 after a report of edema to the right lower extremity. Resident #17 The findings include: On January 17, 2006 at approximately 9:40 AM Resident #17 was assessed and the resident was observed sitting in a wheel chair transferred to the hospital for with his/her leg in a dependent position with treatment, 1/17/06. edema to the right foot and leg. All residents with lower During the review of the clinical record, a nurse's note dated January 10, 2006 at 5:58 AM Extremity Edema were indicated, " Alert and verbal, CNA alerted me to reassessed and checked the fact that the resident's right lower extremities to ensure compliance. were swollen, right foot elevated with pillow - no agitation noted this shift. Will continue to monitor All Nursing Staff will be temperature (T) 98- pulse (P) 70, respiration (R) 20, and blood pressure (B/P) 140/70. Right lower in-serviced on daily assessment extremities edematous, next shift will follow up. " of all residents during AM Care and to report abnormal The 24-Hour Nursing Report was reviewed for findings to the RCC and onto January 9, 2006. Documentation on the night the physician. 2/28/06. shift report indicated, "Right lower extremity

and P 70."

swollen edematous +3, B/P 140/70, R 20, T 98

According to the 24-Hour Nursing report and a

physician's progress note dated January 13, 2006, the resident was visited by the physician.

However, there was no documentation regarding

On January 17, 2006 at approximately 10:30 AM,

edema of the resident's right lower extremity.

the RCC (Resident Care Coordinator) was

3/6/06

All deficient practices regarding physician documentation will be

discussed in the monthly Risk

Management/QA meeting.

quarterly QA meeting and

remedial actions

reported immediately to the Administrator for further

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES					: 02/07/2006
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES					APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE C	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		095031	B. WIN	G		04/2	0/2006
NAME OF	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	01/2	0/2006
ROCK	CREEK MANOR NURSI	NG CTR		2131 O	STREET NW INGTON, DC 20037		
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F 309	Continued From page	ge 5	F 30	09			
	She indicated that hedema to the reside January 10, 2006. Facility staff failed to lower extremity after	nowledged the edema. He/e/she was not aware of the nt's right lower extremity on reassess the resident's right January 10, 2006 when it dema. The record was 18, 2006.					
F 363 SS=C	Menus must meet th residents in accordar dietary allowances of Board of the Nationa	e nutritional needs of need with the recommended the Food and Nutrition Research Council, National s; be prepared in advance;	F 36	1	The alternate entrée menu was dated and revised to include a vegetable substitute. 1/30/06. All alternate entrée menu were reviewed and updat to meet Compliance.		
	Based on observation it was determined that were not dated and fasubstitute. This finding presence of the dietiti. The findings include: Through observation a with the dietitian on Jacobs 11:00 AM on both day alternate entree menu.	and a face-to-face interview nuary 17 and 18, 2006 at s, it was determined that s on residents' bulletin were not dated and lacked in two (2)		3a. 3b.		or and kly	

DEPAR	TMENT OF HEALTH	H AND HUMAN SERVICES): 02/07/200
CENTERS FOR MEDICARE & MEDICAID SERVICES							1 APPROVED 0. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	SURVEY
		095031	B. WIN	۱G		01/2	20/2008
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	UIIZ	20/2006
ROCK C	CREEK MANOR NURSI	ING CTR		21	VASHINGTON, DC 20037		
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F 309	Continued From page	ige 5	F3	309			
	She indicated that hedema to the reside January 10, 2006.	knowledged the edema. He/ he/she was not aware of the ent's right lower extremity on			4. The Director of Food Swill report problems we residents menus to the Administrator and discontinuous problems at the	vith	
	lower extremity after	o reassess the resident's right er January 10, 2006 when it edema. The record was ry 18, 2006.			those problems at the quarterly QA meeting to remedial action.	for	3/6/06
F 363 SS=C	483.35(c) MENUS A ADEQUACY	AND NUTRITIONAL	F 30	63	*		
	residents in accorda dietary allowances o Board of the Nationa	he nutritional needs of ance with the recommended of the Food and Nutrition al Research Council, National es; be prepared in advance;					
	This REQUIREMEN	IT is not met as evidenced by					
	it was determined that were not dated and f	ons during the survey period, nat alternate entree menus failed to include a vegetable ling was observed in the itian.					
	The findings include:	: *					
	with the dietitian on J 11:00 AM on both day	n and a face-to-face interview January 17 and 18, 2006 at ays, it was determined that hus on residents' bulletin					

boards for those days were not dated and lacked a vegetable substitute in two (2) of two (2) observations on January 17 and 18, 2006.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO						
					OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED		
		095031	B. WIN	IG	01/2	0/2006
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROCK	CREEK MANOR NURSI	NG CTR	1	2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETION DATE
F 371 SS=E	PREP & SERVICE	ARY CONDITIONS - FOOD re, prepare, distribute, and nitary conditions.	F3	Sprinkler heads located directly over food preparation area were changed. 1/23/06.		
	Based on observation it was determined the adequate to ensure served in a safe and evidenced by soiled.	sprinkler heads directly over se findings were observed in		2. All sprinkler heads located in the cooking area was checked and changed to meet compliance.3. The Food Service Director and the Director of Maintenance will monitor monthly to ensure compliance.		
	The findings include: Sprinkler heads local preparation areas we dust and debris in thr observations at appro January 17, 2006.	ted directly over food are soiled with accumulated tee (3) of four (4)		4. The Director of Food Servic will report problems of kitchen sanitation to include sprinkler heads to the Administrator and will repowill be given at the quarterly QA meeting for remedial ac	rts	3/6/06
F 386 SS=D	483.40(b) PHYSICIAI	N VISITS	F 38			0,0,0
33-0	program of care, inclutreatments, at each violet of this section; write, so notes at each visit; an with the exception of it polysaccharide vaccinadministered per physical program of the care of the					

02/23/2006 17:03 FAX 2023310857 ROCK CREEK MANOR Ø003/004 DEPARTMENT OF HEALTH AND HUMAN SERVICES PHINTED: 02/07/2006 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 095031 01/20/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW ROCK CREEK MANOR NURSING CTR WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG F 386 Continued From page 7 F 386 1. The PSA (Prostatic Specific This REQUIREMENT is not met as evidenced by Antigen) level for resident #9 Based on record review and staff interview for was repeated and was within one (1) of 25 sampled residents, it was normal limit of 3.6(0-4.0). determined that the physician failed to follow up on an elevated PSA (Prostatic Specific Antigen) 2. All residents with abnormal level for Resident #9 PSA levels were checked and were in compliance. Peated ms 2/24106 The findings include: A review of Resident #9's History and Physical 3. All RCC's including physicians dated February 9, 2005 revealed a diagnosis of will be in-serviced on proper Benign Prostatic hypertrophy (BPH). A laboratory result dated November 1, 2005 for a PSA level documentation of abnormal labs was 10.0 [normal range 0.0 - 4.0]. A PSA level and a follow-up documentation dated July 5, 2005 was 2.4; within normal range. for new orders. 2/28/06. The November 1, 2005 PSA laboratory slip was Deficient practices regarding 4. initialed and dated on November 9, 2005 by the attending physician, indicating review. The physician reviews and attending physician's progress notes dated documentation will be November 9 and December 4, 2005 did not make discussed in the quarterly reference to the elevated PSA level. There was physician Clinical meetings and no documentation in the record that a follow up quarterly QA meeting for was done for the elevated PSA level. remedial actions. 3/6/06 A face-to-face interview was conducted with the attending physician on January 18, 2006 at 12:48 PM. He/She stated, "[Resident] had a UTI (urinary tract infection) around that time [November 1, 2005]. I'm going to get another PSA ." The record was reviewed on January 18, 2006.

483.65(a) INFECTION CONTROL

The facility must establish and maintain an infection control program designed to provide a

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	ND HUMAN SERVICES			FORM	APPROVED
CENTERS FOR MEDICARE &					0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	095031	B. WING		01/2	20/2006
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0 172	.0/2000
ROCK CREEK MANOR NURSING			2131 O STREET NW WASHINGTON, DC 20037		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES IT BE PRECEEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
to prevent the developmedisease and infection. an infection control proginvestigates, controls, at the facility; decides what isolation should be appliated and maintains corrective actions related	fortable environment and nent and transmission of The facility must establish gram under which it and prevents infections in t procedures, such as ied to an individual a record of incidents and d to infections.		 1a. Over bed table of resident as well as that of the rooms was immediately cleaned a sanitized. 1b. The nursing staff was immedian-serviced on proper use as sanitation of over bed tables regarding infection control. 	nate nd ediately nd	
This REQUIREMENT is: Based on observations, if facility staff failed to main to help prevent the develor of disease and infections bedside table before reus side mat; and residents of soiled benches in the countries. The findings include: 1. Facility staff failed to cleafter feeding Resident #17 another resident. On January 17, 2006 at an a CNA was feeding Resides semi-private room, with two His/Her lunch was placed table. The other over bed to supplies for Resident #17's be administered by the lice resident ate his/her lunch. The CNA completed feeding removed the lunch tray from proceeded to place the over	it was determined that intain proper procedures opment and transmission by: failure to wash a se; walking on a bed observed seated on art yard. Resident # 17. ean an over bed table of and reusing it for opproximately 12:15 PM ent #17 who was in a ro (2) over bed tables. On one (1) over bed table was in use with se treatment that was to ensed nurse after the or Resident #17, on the table and	3	2. All nursing staff will be inserviced on sanitizing of over bed tables after each use to prevent cross contamination. 2/15/06. 3. On-going in-services will be conducted to remind staff to always sanitize over bed table after being used by another resident. RCC's (Resident Canadam Coordinators) and team leader will monitor for compliance. All deficient practices relating Infection Control of over bed tables will be discussed in the monthly Risk Management/Quand quarterly QA meeting for further remedial action.	le are ers	/6/06

		AND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 02/07/2000 MAPPROVEI 0: 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
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	of the resident's roo The surveyor was le CNA was entering th Resident #17's room was not washed befoon the table. The tra resident started eatin On January 18, 2006 a face-to-face intervi RCC (Resident Care acknowledged that th table and indicated th recently on infection 2. A CNA was observative mat. On January 17, 2006 CNA was preparing th dinner. A covered fat floor at the resident's the dinner tray to the on the mat and place table. After placing the placed the folded mat On January 18, 2006 a face-to-face intervier RCC who acknowledge on the mat and indicate serviced recently on in B. Residents were observed in the courty of droppings on the serviced droppings on the	aving the room and another ne room with a lunch tray for mate. The over bed table ore the CNA placed the tray ay was uncovered and the ng his/her lunch. So at approximately 11:00 AM ew was conducted with the coordinator) who he CNA failed to wash the nat the staff was in-serviced control practices. Yed walking on a fall at approximately 5:00 PM a possible feed Resident #17 his/her are protective mat was on the bedside. The CNA bought resident's bedside, stepped at the tray on the table, the CNA against the wall. at approximately 11:00 AM was conducted with the ged that the Staff was infection control practices. Served seated on wooden and that were soiled with seat and back surfaces in servations at approximately	F 44	 The protective floor mat resident #17 was sanitized. 2/19/06. All residents' protective mats were checked and sanitized to ensure comp. All residents' with fall properties floor mats were identified preventative measure to staff not to walk on the finat. All staff will be in-service Infection control measure regarding residents' fall protective floor mats and Team Leader/RCC's (Resident Care Coordinate will monitor for compliance) Problems with residents' fall Protective floor mats at to infection control will be discussed in the quarterly QA meeting for remedial action. 	floor liance. rotective d as a alert loor ed on es ors) ce. with relating e	3/6/06

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES					D: 02/07/200 MAPPROVE
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AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		095031	B. WI	NG_			
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	01/2	20/2006
ROCK	REEK MANOR NURSI	NG CTR		2	1131 O STREET NW VASHINGTON, DC 20037		
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	Continued From page of the resident's room. The surveyor was le CNA was entering the Resident #17's room was not washed before the table. The transident started eating the continuation of the table. The transident started eating the continuation of the table and indicated the recently on infection of the table and indicated the recently on infection of the continuation of the mat and placed the folded materials. On January 17, 2006 CNA was preparing to dinner. A covered fall floor at the resident's the dinner tray to the continuation of the mat and placed the folded materials. After placing the collection of the mat and indicated the materials. Residents were observed in the courty as the courty and the courty are continuated to the courty are continuated. Residents were observed to the courty are continuated to the courty are continu	ge 9 m mate's bed. aving the room and another ne room with a lunch tray for nmate. The over bed table ore the CNA placed the tray ay was uncovered and the ng his/her lunch. at approximately 11:00 AM ew was conducted with the Coordinator) who ne CNA failed to wash the nat the staff was in-serviced control practices. yed walking on a fall at approximately 5:00 PM a of feed Resident #17 his/her Il protective mat was on the bedside. The CNA bought resident's bedside, stepped at the tray on the table, the CNA against the wall. at approximately 11:00 AM was conducted with the led that the CNA stepped ted that the Staff was infection control practices. Between the staff was infection control practices. Between the company the staff was infection control practices.	F 4	141	 Bird dropping on all courbenches were cleaned. 1/2 Benches on the courtyard, checked by the Director of Maintenance and found to compliance. The Director of Maintenancheck courtyard benches during courtyard clean up during smoking period to a compliance. Problems related to bird droppings, on benches and courtyard will be reported Director of Maintenance on to the Administrator for remedial action and will be discussed in the quarterly QA meeting. 	tyard 20/06. were be in nce will laily and ensure	3/6/06
tl	ird droppings on the s	seat and back surfaces in servations at approximately					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/07/2006 I APPROVED
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