	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURV COMPLETED	
		095031	B. WING		10/13/:	2009
	(EACH DEFICIENCY MUST OR LSC IDE	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	2	REET ADDRESS, CITY, STATE, ZIP CODE 131 O STREET NW WASHINGTON, DC 20037 PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETR DATE
F 000			F 000	1a Spanish speaking staff n identified-and-the-resider responsible party has giv	nt#18's	
F 241 SS=D	October 6 through 1 deficiencies were bar review and staff and sample included 26 173 residents on the supplemental reside were investigated: 09-042 [DC0000170 061 [DC00001748]. 483.15(a) DIGNITY The facility must pro- manner and in an er enhances each resid recognition of his or This REQUIREMEN Based on record rev interviews for two (2)	T is not met as evidenced by: ew, resident, staff and family of 26 sampled residents, it	F 241	<ul> <li>consent to use them as written consent form has the responsible party for affirmation.</li> <li>1b. On call Spanish speakin program for non adminis and weekends was initia (See attachment 1A,1E</li> <li>1c. The facility already has e speaking staff to help du administrative hours.</li> <li>1d. Policy on non-English spwas revised on 11/2/09 (See attachment II).</li> <li>1e. Facility's communication English speaking resident frequently used Spanish updated to include more</li> <li>2. Care Plans of all Spanish residents were reviewed</li> </ul>	interpreters. A s been mailed to a written ag interpreter strative hours ated on 10/26/09 <b>3 &amp; 1C).</b> enough Spanish uring beaking residents book for non- nts with words was words. h speaking on 10/30/09 for	
	was determined that care in a manner and maintains or enhance	facility staff failed to promote d in an environment that es the resident 's dignity and in resident's individuality.		inclusion of on-call Span interpreter. 3a. Staff were in-serviced or Speaking Program relativ	ish speaking n Non-English ve to interpreter	
	The findings include:			and contact numbers on staff meeting. 3b. Nurses will document ea	ch time the	
	for communicating w primary language-Sp	to ensure appropriate provision ith the resident in his/her anish and to honor the to use adult briefs for Resident		services of the on-call tra 3c. IDT members will review plan of care for appropria during the care conference	the residents' ite intervention	
		erly MDS completed on the resident is 99 years old.				

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

					$\vee$		
ດຕ້ຳນວ	דאראד מל נולאן דנו	AND HUMAN SERVICES				PRINTED:	
	•	& MEDICAID SERVICES					PPROVE
		1	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-	
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	<u> </u>
		1	A. BUIL	DING		{	
		095031 B. WING				10/13/2	0000
			T			10/13/2	2009
NAME OF P	ROVIDER OR SUPPLIER		1		ET ADDRESS, CITY, STATE, ZIP CODE 31 O STREET NW		
ROCK C	REEK MANOR NURSIN	IG CTR			ASHINGTON, DC 20037		
			l				·····
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 241		· ·	F 2	241	4. Problems related to commun		
	-Section-B-Cognitive	-Patterns-was-coded as-long-			barriers between residents a		
		"; short-term memory "problem".			be reported to the DON, the	Administrator	1
		zero (O) [Meaning behavior was on E-Mood and Behavior		ļ	and discussed in the Risk Management/QA meeting an	d in the	}
		equired limited assistance with			Quarterly QA meeting.	u in die	11/27/09
		r, and walk in room and corndor					
		al Functioning and Structural		}			
	continent of bowel a	H the resident was coded as					l
	The nursing notes re	evealed the following:					
	member to use com	am] held for residentStaff munication book when dent, diapers for resident at			1a. Use of brief on the resident	#18 was	
				Í	discontinued on 10/9/09.	4.040.000	
		9 at 10: 00 PM,Staff		j	1b. A toileting plan was initiated	i on 10/9/09.	
		t to wear [adult briefs] at night lerstand resident's language			2. Care of all continent resider	nts with	
	(Spanish) "	icistand resident s language			potential for fall was review		[
					appropriate treatment plan	on 10/30/09.	
	"September 27, 200	9 at 2:00 AM, Many attempts					
	made to encourag brief] at night but co staff could not unde	e resident with the use of [adult ontinue to speak Spanish when rstand "			3a. Nursing staff were re-in-set management of continent r potential for fall by 10/30/0	esidents with 9.	
	10	0 01 2:00 001 - 51-55			3b. IDT members were retrained		{
		9 at 2:00 AMStaff to wear [adult briefs] "			plan decisions that reflect L		
					regulations and holistic app resident dignity and safety		
	Employee #7 on Oc	tober 6, 2009 at approximately			4. Deficient practice and staff i		
		said, "After the resident has had bealed to the resident to use			related to issues of residen	t safety and	
		at night to reduce the incidents			dignity will be reported to the		
		esident refused. During the last		}	Administrator for remedial a		
	IDT meeting we	-			discussed in the monthly R Management /QA and Qua		ł
	}				meeting.	nony QA	11/27/09
					······		

Facility ID: ROCKCREEK

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		AND HUMAN SERVICES			OMB NO	M APPROVI D. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095031	B. WING		10/:	3/2009
	ROVIDER OR SUPPLIER		1	ET ADDRESS, CITY, STATE, ZIP CO 11 O STREET NW	DE	
ROCKCE			AW .	ASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETIO DATE
F 241	Continued From pa	ge 2	F 241			
	presented the use of	of-adult-briefs-at-night-with-the-				-
	family, they agreed persuaded the resident factors only. The resident h	with the team. The family lent to use adult briefs at night las not had a fall incident since e of adult briefs at night. "				
·	Employees #2 and approximately 1:00	view was conducted with 7 on October 9, 2009 at PM. Employee #2 stated, "That institute an every 2-hour"				
	assistant/reminder the importance and update the community their needs and or of	to the bathroom and emphasize need for the night shift staff to nication book as needed to meet contact the identified staff		· · ·		
	#2 also added that interventions that w	lable after off-hours. Employee the facility would explore other ill assist in maintaining and or lent's dignity and is acceptable to		• •		
	13, 2009 at 1:00 PM presence of the fam translated for this in family member, the	view was conducted on October A with the resident in the hily member. The family member avestigator. According to the resident protested the idea of				
	brief only at night to related to fall. The f there is no Spanish if and when the resi	ut was persuaded to use the reduce the potential for fracture amily member stated because speaking staff on the night shift, ident calls for help, the staff are they do not understand the				
	resident, and they a the resident in his/h	they do not understand the are unable to communicate with er primary language and are provide the resident with services.				
	J					

Event ID: 2J6R11

Facility ID: ROCKCREEK

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	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		FORM A <u>OMB_NO. (</u>	PPROVE 938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURV COMPLETED	
		095031	B, WING		10/13/2	2009
	ROVIDER OR SUPPLIER	IGCTR		REET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW		
(X4) ID	SUMMARY ST		<b>I</b> D,	PROVIDER'S PLAN OF CORI	RECTION	
PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETI DATE
F 241		ge 3 b-ensure-appropriate-provision	F 241	1a Resident #23 received n from-America's Best €or	ew eye glasses	
	<ul> <li>primary language-Sp wishes not to use ac Additionally, a review lacked evidence that appropriate intervent bathroom use and correviewed October 13</li> <li>2. Facility staff failed personal possession and eyeglasses that resident's room during painted.</li> <li>During the resident of State Agency on Oct 1:30 PM and a face- 2009 at approximate verbalized the loss of obtained eyeglasses</li> <li>Resident # 23 allege dentures were in the nightstand. Resident</li> </ul>	w of the resident's clinical record t facility staff explored other tions to aid in the resident's ontinent care. The record was 3, 2009. to return Resident #23's is including his/her dentures were removed from the ng the time when the room was council group meeting with the tober 8, 2009 at approximately to-face interview on October 9, ly 3:45 PM, Resident #23 f his/her dentures and newly		<ul> <li>Connecticut Ave., NW, V 20036 on 11/06/09.</li> <li>1b. An inventory form for resinitiated to track resident items when they are moved to the resident's room due sanitation process.</li> <li>2. Other residents with eye to been re-assessed and eye found to be in good conder properly cared for on 10/</li> <li>3a. An updated personal provide the kept for all resident sheet will be kept in resident and a sin-server 10/21/09 on the proper of eye glasses' including do 3c. RCC will monitor for configuration of the server compliance in case of to</li> <li>4 Problems related to eye gravity and the server and the server of the server of the server of the server and the server of the server of the server of the server compliance in case of the server o</li></ul>	ident #23 was s' personal red and returned ring room glasses have reglasses were ition and 30/09. operty inventory lent chart. iced on are of residents' ocumentation. apliance. e timely ss.	
	possessions. The en nightstand without hi explanation of where be kept or returned. A face-to-face intervi Employee #17 on Oc approximately 2:55 F is not aware of the re a fact that the reside	htire contents from his/her s/her permission, and or the personal possessions will ew was conducted with ctober 9, 2009 at PM. He/she stated that he/she esident's dentures but knows for int had newly prescribed ee #17 stated that he/she		assistive devices will be n DON, the Administrator at the Risk Management/Q/ the Quarterly QA meeting	nd discussed in A meeting and in	11/27/0

Facility ID: ROCKCREEK

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB_NO.</u> [	PPROVE 938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVI COMPLETED	
		095031	B. WING		10/13/2	2009
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCK C	REEK MANOR NURSIN	IG CTR	1	2131 O STREET NW NASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETIC DATE
F 241			F 241	1. Resident #25 was seen by	facility's	
	that the eyeglasses on April 27, 2009 an room was completed A face-to-face interv 9, 2009 at 3:10 PM v acknowledged that t dentures and newly Employee #23 state resident on the trip f eyeglasses. Facility staff failed to possessions includir eyeglasses that wer the resident's room. A face-to-face interv Employee #7 on Oct 5:00 PM. He/she act been informed of the allegation and that th the resident's missin reviewed October 9,	iew was conducted on October with Employee #23. He/she he resident had a pair of old prescribed eyeglasses. d that he/she accompanied the or the fitting and pick-up of the return Resident #23's personal g his/her dentures and e moved during the painting of iew was conducted with ober 9, 2009 at approximately knowledged that he/she had e validity of the resident's ne facility will have to replace g property. The record was 2009.		<ul> <li>dentist on 11/13/09 and dentist on 11/13/09 and dentist impressions taken.</li> <li>2. Other residents with dentur re-assessed and dentures from the condition on 10/30/09.</li> <li>3a. An updated personal proper Including dentures will be fresidents.</li> <li>3b. Nursing staff was in-service proper care of resident der Including documentation of 3c. RCC will monitor for compl 3d. Social Services will ensure compliance in case of loss.</li> <li>4. Problems related to dentur assistive devices will be re and the Administrator for re and discussed in the Risk Management/QA meeting Quarterly QA meeting.</li> </ul>	es have been ound in good erty inventory cept for all ed 10/21/09 on ntures, n each shift. iance. timely es and other ported to DON emedial action	11/27/09
F 250 SS=D	services to attain or physical, mental, and each resident. This REQUIREMEN Based on staff interv	vide medically-related social maintain the highest practicable d psychosocial well-being of T is not met as evidenced by: iew and record review for one sidents, the social worker failed	F 250	<ol> <li>Resident #11 was not harr deficient practice.</li> <li>The residents psychosocia was completed on 10/29/0</li> <li>Social Workers will audit of ensure that all psychosocia assessments are completed date. Completion date 11/</li> </ol>	Il assessment 9. harts to al ed and up to	

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STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURV COMPLETED	EY
		095031	8. WING		10/13/2	2009
	ROVIDER OR SUPPLIER	NG CTR	( :	REET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037	10/13/	2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETI DATE
F 250	communication lang The findings include A review of the clinic social worker failed resident's psychoso of July 20, 2009. A review of the adm note" dated July 28 "Social worker me assessment. Resid 2009. This worker we the time of admission was up in Gen-chain Resident has expres at social worker but answer questions. I initial assessment [family member] is w [family member] to a paperwork" A review of nurse's n [family member] visi dates: 7/21/2009, 7/22/200 7/26/2009, 7/31/200 8/16/2009, 8/28/200 Although the [family facility on the aforem record lacked evider	for Resident #11 with a guage barrier. cal record revealed that the to assess and/or document the cial needs since admission date ission "social worker progress , 2009 at 1:25 PM revealed, t with resident for initial ent was admitted on July 20, vas out of facility on vacation at m. Met with resident. Resident c. Reviewed resident record. ssive aphasia. Resident looked was unable to express and Discussed resident in IDT for According to IDT members ery supportive. Will contact assist with admission note revealed that resident's ted facility on the following 9, 7/23/2009, 7/25/2009, 9, 8/2/2009, 8/4/2009, 8/7/2009, 9, 9/14/2009 and 9/18/ 2009. member] was present in the nentioned dates, the clinical nce of the social worker's the family to further assess the	F 250	<ul> <li>3a. Social Workers were in-ssecial worker consultant frame to complete psychelassessments on 10/30/03</li> <li>3b. Medical records staff will monthly audit to ensure of initial and quarterly psychessessments.</li> <li>4. Problems related to the accompletion of psychosocowill be reported to the Adaddressed in the monthly Management/QA and Quarterly for remedial activity.</li> </ul>	on the time osocial 9. continue with a completion of hosocial accurate/timely ial assessments lministrator and / Risk uarterly QA	11/27/0

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Facility ID: ROCKCREEK

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

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PRINTED:	10/27/2009
FORM A	APPROVED
OND NO	1000 0004

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURV COMPLETED	
		095031	B. WING			2009
	ROVIDER OR SUPPLIER	NG CTR	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(X5) COMPLETIC DATE
F 250	Continued From pa	-	F 25	50		
	assessment and to-	complete-paperwork	<b></b>		· · · · · · · · · · · · · · · · · · ·	
	Employee #15 on C He/she acknowledg member] was called has not been able to	view was conducted with October 7, 2009 at 2:00 PM. les that resident's [family d and message left but he/she o contact or speak with the le record was reviewed October				
F 253 SS=E	The facility must pro maintenance servic	EKEEPING/MAINTENANCE ovide housekeeping and es necessary to maintain a id comfortable interior.	F 25	1. Loose privacy curtain the secured and completed contractor by 11/27/09 f rooms 102,103,108,110 119,120,203,204,206,2 218,219 and 221(See a	by outside for residents in ),114,115,117, 10,212,213,214,	
	This REQUIREMEN	IT is not met as evidenced by:		2. All privacy curtain track 10/19/09 and found to b	s were checked on be in compliance.	
	October 6 and 7, 20 AM, it was determin provide effective ho services as evidenc were loose in 19 of privacy curtains in fe dusty air vents and (5)shower rooms; d five (5) resident sho and soiled walls in t observations were r Employees #12 and The findings include 1. Privacy curtain the resident's rooms ob	e: racks were loose in 19 of 50 served; rooms 102, 103, 108, 119, 120, 203, 204, 206, 210,		<ul> <li>3a. The Director of Environ and the Maintenance I all privacy curtain track grand rounds to ensure</li> <li>3b. Loose privacy curtain to checked and recorded technicians in the main quick repairs by mainte</li> <li>4. The Director of Environ will report problems of curtain tracks to the Ad discussed in the month Management/QA and 0 meetings for remedial a</li> </ul>	Director will monito as during weekly they are secured racks will be by housekeeping ntenance log for enance. mental Service loose privacy lministrator and nly Risk Quarterly QA	

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

Facility ID: ROCKCREEK

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STATEMENT OF DEFICENCIES AND PLAN OF CORRECTION         (X) provider Rumpurgencua Destrification Number         (Q) MULTIPLE CONSTRUCTION A BULENIG         (X) DATE Survey ComPleter Destrification Number           NAME OF PROVIDER OR SUPPLIER         095031         IV MIG         10/13/200           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PAND PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200           STREET ADDRESS, CITY, STATE, ZIP CODE         2010/17/200/17/200         2010/17/200/17/200           STREET ADDRESS, CITY, STATE, ZIP CODE		1	AND HUMAN SERVICES & MEDICAID SERVICES		$\checkmark$		<b>PPROVED</b>
Image of PROVIDER OR SUPPLIER       10/13/200         ROCK CREEK MANOR NURSING CTR       STREET ADDRESS, CITY, STATE, ZIP CODE         PROY       SUMMARY STATEMENT OF DEPICIENCIES       Image: Comparison of the compar	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURV	ΈΥ
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ROCK CREEK MANOR NURSING CTR     STREET ADDRESS, CITY, STATE, ZIP CODE       VASHINGTON, DC 20037     SUMMARY STATEMENT OF OEPICIENCIES       PREFIX     Continued From page 7       TAG     SUMMARY STATEMENT OF OEPICIENCIES       PREFIX     PROVIDERS PLAN OF CORRECTIVE ACTIONS SHOULD BE CROSS.       REFERENCE TO THE APPROPRIATE DEFICIENCY     PREFIX       PREFIX     PROVIDERS PLAN OF CORRECTIVE ACTIONS SHOULD BE CROSS.       REFERENCE TO THE APPROPRIATE DEFICIENCY     Continued From page 7       2. Privacy-curtains were damaged in-four-(4)-of-50     F 253       13. Air vents were dusty and walls were soiled in five     11/15/09.       14. Ceiling tiles were damaged in the first and third     10. Contract bids are taken to get a proposal       10 or shower rooms in two (2) of five (5) shower     10. Contract bids are taken to get a proposal       11/15/09.     10. Contract bids are taken to get a proposal       11/15/09.     11/15/09.       12. Privacy-curtains for other residents have       13. Sir vents were observed.     10. For (5) shower       14. Ceiling tiles were observed in the rehabilitation area     2. Privacy-curtains for other residents have       14. Solied walls were observed in the rehabilitation area     3. The Director of Environmental Service       15. Binds were acknowledged by Employees #12     3. The Director of Environme		· .	095031	B. WING	<u> </u>	10/13/	2009
PREFIX TAG       CEACH DEFICIENCY MUST BE PRECED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH DEFICIENCY MUST BE PRECED TO ALL PROPRATE DEFICIENCY TAG       Contract bits are taken to get a proposal to replace all privacy curtains on the 1 <sup>st</sup> and 319.         F 253       Continued From page 7       F 253       1a. The damaged privacy curtains in rooms         J. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.       F 253       1a. The damaged privacy curtains in rooms         J. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.       F 263       1a. The damaged privacy curtains on the 1 <sup>st</sup> and 3 <sup>rd</sup> floors (See attachment IV).         J. C. Room 319 is a private room and never nooms observed.       A ceiling tiles were damaged in thre (3) of five (5) blinds observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.       Privacy curtains for other residents have been assessed and will be replaced or repaired as needed by 11/27/09.         F 278       483.20(g) - (0) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.       F 278       4. The Director of Environmental Service Will submit problems with tom privacy Curtains to the Administrator for remedial Action and will be discussed in the Risk Management/QA meeting and Quarterly QA meeting.       11/1			IG CTR		2131 O STREET NW		2005
2. Privacy-curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319.       1144,417;301-and 319 will be replaced on 11/15/09.         3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.       1b. Contract bids are taken to get a proposal to replace all privacy curtains on the 1 <sup>st</sup> and 3 <sup>cd</sup> floors (See attachment IV).         4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.       1b. Contract bids are taken to get a proposal to replace all privacy curtains on the 1 <sup>st</sup> and 3 <sup>cd</sup> floors (See attachment IV).         5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.       2. Privacy curtains for other residents have been assessed and will be replaced or repaired as needed by 11/27/09.         5. Solied walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.       3a. The Director of Environmental Service will monitor and check all privacy curtains to ensure they are clean and in good condition.         5. F 278       483.20(g) - (i) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.       F 278         A registered nurse must conduct or coordinate each assessment with the appropriate participation of       F 278         A registered nurse must conduct or coordinate each assessment with the appropriate participation of       F 278	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE CROSS-	(XS) COMPLETION DATE
health professionals.         A registered nurse must sign and certify that the assessment is completed.         Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.         Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278	<ol> <li>2. Privacy-curtains w resident's rooms obs and 319.</li> <li>3. Air vents were due (5) of five (5) shower</li> <li>4. Ceiling tiles were floor shower rooms in rooms observed.</li> <li>5. Blinds were obser of five (5) blinds obs</li> <li>6. Soiled walls were area in one (1) of on observed.</li> <li>The findings were are and 30.</li> <li>483.20(g) - (j) RESIE</li> <li>The assessment mu resident's status.</li> <li>A registered nurse m assessment with the health professionals.</li> <li>A registered nurse m assessment is comp</li> <li>Each individual who assessment must sig that portion of the ass</li> <li>Under Medicare and</li> </ol>	vere-damaged-in-four-(4)-of-50 served, rooms #114, 117, 301 sty and walls were soiled in five r rooms observed. damaged in the first and third in two (2) of five (5) shower ved to be damaged in three (3) erved in the rehabilitation area. observed in the rehabilitation e (1) rehabilitation area cknowledged by Employees #12 DENT ASSESSMENT st accurately reflect the nust conduct or coordinate each appropriate participation of hust sign and certify that the leted. completes a portion of the gn and certify the accuracy of sessment. Medicaid, an individual who		<ul> <li>144,147,301 and 319 will b 11/15/09.</li> <li>1b. Contract bids are taken to to replace all privacy curta and 3<sup>rd</sup> floors (See attachund)</li> <li>1c. Room 319 is a private roo had a privacy curtain.</li> <li>2. Privacy curtains for other repaired as needed by 11/2</li> <li>3a. The Director of Environme will monitor and check all provide the second to the second to the direct to ensure they are clean a condition.</li> <li>3b. Housekeeping technician to check for damaged prive to be reported to the Direct Environmental Services.</li> <li>78</li> <li>4. The Director of Environme Will submit problems with for Curtains to the Administrat Action and will be discussed Management/QA meeting at the second to the second</li></ul>	e replaced on get a proposal ins on the 1 <sup>st</sup> <b>nent IV).</b> m and never esidents have replaced or 27/09 ntal Service orivacy curtains nd in good will be trained acy curtains tor of ntal Service orn privacy or for remedial d in the Risk	

Facility ID: ROCKCREEK

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· · ·		AND HUMAN SERVICES & MEDICAID SERVICES			v	FORM A OMB NO. 0	PPROVE 938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		095031	B. WIN	G		10/13/2	2009
NAME OF PR	ROVIDER OR SUPPLIER		ĺ		EET ADDRESS, CITY, STATE, ZIP CODE		
ROCKCF	REEK MANOR NURSIN	IG CTR			131 O STREET NW VASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(XS) COMPLETI DATE
F 253	Continued From page	ge 7	· F2	253	1. Soiled exhaust vents an	d walls located in	
	resident's rooms obs and 319. 3. Air vents were du (5) of five (5) showe 4. Ceiling tiles were floor shower rooms i rooms observed. 5. Blinds were obser of five (5) blinds obs 6. Soiled walls were area in one (1) of on observed.	vere-damaged-in-four-(4)-of 50 served, rooms #114, 117, 301 sty and walls were soiled in five r rooms observed. damaged in the first and third in two (2) of five (5) shower rved to be damaged in three (3) erved in the rehabilitation area. observed in the rehabilitation e (1) rehabilitation area cknowledged by Employees #12			<ul> <li>the five shower rooms w 10/13/09.</li> <li>Soiled exhaust vents thr facility have been check Director of Maintenance and found to be in comp</li> <li>Exhaust vents will be ch weekly during Grand Ro Director of Maintenance compliance.</li> <li>Deficient practice related exhaust vents will be rep immediately to the Direct Maintenance unto the A remedial action and disco monthly Risk Manageme Quarterly QA meeting.</li> </ul>	ere cleaned on oughout the ed by the on 10/13/09 liance . ecked daily and ounds by the for continued for continued to soiled ported tor of dministrator for ussed in the	11/27/0
F 278 SS=D	The assessment muresident's status. A registered nurse rassessment with the health professionals A registered nurse rassessment is complete the comp	nust sign and certify that the bleted. completes a portion of the gn and certify the accuracy of	F2	278			
	Under Medicare and willfully and knowing	d Medicaid, an individual who gly certifies a material and		,			

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Facility ID; ROCKCREEK

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If continuation sheet Page 8 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: FORM / OMB NO.	APPROVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURV COMPLETE	/EY
		095031	B, WIN	IG		10/13/	2009
	ROVIDER OR SUPPLIER	NG CTR	_1	:	REET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037		2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 253	resident's rooms obs	ge 7 vere-damaged-in-four-(4)-of-50 served, rooms #114, 117, 301	F	253	<ol> <li>First and third floor damaged in the shower roor repaired on 10/13/09.</li> </ol>	ed ceiling tiles ns were	
	<ul><li>(5) of five (5) showe</li><li>4. Ceiling tiles were</li></ul>	sty and walls were soiled in five r rooms observed. damaged in the first and third in two (2) of five (5) shower			<ol> <li>Ceilings tiles through out have been checked by th Maintenance and found to compliance on 10/13/09.</li> <li>Ceiling titles will be check weekly during Grand Rou</li> </ol>	e Director of be in ed daily and nds by the	
	of five (5) blinds obs 6. Soiled walls were area in one (1) of on observed.	rved to be damaged in three (3) erved in the rehabilitation area. observed in the rehabilitation e (1) rehabilitation area cknowledged by Employees #12			<ul> <li>Director of Maintenance f compliance.</li> <li>4. Deficient practice related Ceilings will be reported in the Director of Maintenan Administrator for remedial discussed in the monthly Management /QA and Qu meeting.</li> </ul>	to damaged nmediately to ce unto the action and Risk	11/27/09
F 278 SS=D	The assessment mu resident's status.	DENT ASSESSMENT	F2	278			
	assessment with the health professionals	nust sign and certify that the					
	Each individual who	completes a portion of the gn and certify the accuracy of					
		Medicaid, an individual who ly certifies a material and					

		& MEDICAID SERVICES	(Y2) 14		E CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILI			(X3) DATE SURVI COMPLETED	
		· ·	B. WING				
	·	095031	D. Wilde	·		10/13/2	2009
IAME OF P	ROVIDER OR SUPPLIER		}	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ROCKC	REEK MANOR NURSI	NG CTR			31 O STREET NW ASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE
F 253	Continued From page	ge 7	 F 2	53	1. The 3 damaged window b	linds located in	
		vere-damaged in four-(4) of 50 served, rooms #114, 117, 301			the rehabilitation room we 10/13/09.	re replaced on	
	(5) of five (5) showe	sty and walls were soiled in five r rooms observed. damaged in the first and third			<ol> <li>Window blinds throughou have been checked by the Maintenance and found to compliance on 10/13/09.</li> </ol>	ne Director of to be in	
	floor shower rooms rooms observed.	n two (2) of five (5) shower			<ol> <li>Window blinds will be che weekly during Grand Rou Director of Maintenance f</li> </ol>	nds by the	
•	5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.		or continued				
		observed in the rehabilitation e (1) rehabilitation area			<ol> <li>Deficient practice related blinds will be reported imp Director of Maintenance u Administrator for remedial</li> </ol>	nediately to the into the	
	The findings were ad and 30.	knowledged by Employees #12			discussed in the monthly Management /QA and Qu meeting.	arterly QA	11/27/09
F 278 SS=D	483.20(g) - (j) RESII	DENT ASSESSMENT	F 27	78			
	The assessment mu resident's status.	st accurately reflect the					
		nust conduct or coordinate each appropriate participation of					
	A registered nurse n assessment is comp	nust sign and certify that the leted.					
		completes a portion of the gn and certify the accuracy of sessment.				-	
		Medicaid, an individual who ly certifies a material and					

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Facility ID: ROCKCREEK

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	RS FUR MEDICARE	& MEDICAID SERVICES			<u>OWB NO. (</u>	0 <u>938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		095031	B. WING	·	10/10/	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/13/:	2009
ROCK C	REEK MANOR NURSIN	IG CTR		2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE C	BE CROSS-	(X5) COMPLETION DATE
F 253	- ·· · · ·	-	F 25	<sup>53</sup> 1. Soiled walls in the rehabilitat	ion area were	÷
199 <u> </u>	resident's rooms obs and 319.	rere-damaged-in-four-(4)-of-50 served, rooms #114, 117, 301 sty and walls were soiled in five		<ul> <li>cleaned on 10/19/09.</li> <li>2. All walls were checked on 1 throughout the facility and for compliance.</li> </ul>	1/3/09	
	4. Ceiling tiles were	damaged in the first and third n two (2) of five (5) shower		3 The Director of Environmen will check all walls during da cleanliness and to ensure ir clean-up by housekeeping t	aily rounds for nmediate	
	of five (5) blinds obs 6. Soiled walls were area in one (1) of on observed. The findings were ac	ved to be damaged in three (3) erved in the rehabilitation area. observed in the rehabilitation e (1) rehabilitation area knowledged by Employees #12		<ol> <li>The Director of Environment will report problems with soil to the Administrator for reme and will be discussed in the Management/QA meeting an QA meeting.</li> </ol>	led walls edial action Risk	11/27/09
F 278 SS=D	and 30. 483.20(g) - (j).RESI	· · · · · · · · · · · · · · · · · · ·	F 27	<sup>8</sup> MDS assessments for:		
	resident's status. A registered nurse m assessment with the health professionals.	oust sign and certify that the		<ul> <li>1a. Resident #3 was corrected pressure ulcer stage 3 wour 10/29/09.</li> <li>1b. Resident #4 was corrected to reflect resident long actin intramascular injection.</li> <li>1c. Resident #6 was corrected of for a fracture that never occurst.</li> </ul>	nd on on 10/29/09 g on 10/07/09, curred.	
	assessment must sig that portion of the as	completes a portion of the in and certify the accuracy of sessment. Medicaid, an individual who		<ul> <li>1d. Resident #15 initial assessr section signed 10/29/09.</li> <li>1e. Resident #22 was corrected to reflect resident correct co enteral feeding</li> </ul>	on 10/29/09	

		& MEDICAID SERVICES				OMB NO. 0	938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDIN				
		095031	B. WING			10/13/2	2009
NAME OF PR	ROVIDER OR SUPPLIER		STF	REET	ADDRESS, CITY, STATE, ZIP CODE		
ROCK CI	REEK MANOR NURSIN	IG CTR	L L		STREET NW		
				/VAS⊦ ⊤	HINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLET DATE
F 278	Continued From pag	je 8	F 278	2.	Other MDS assessments	were reviewed	
Band Challenge & California an		resident-assessment-is-subject			on 11/3/09 for miscoding r	elated to	
		alty of not more than \$1,000 for r an individual who willfully and			fracture, long acting intram		ļ
	knowingly causes ar	nother individual to certify a		}	injections, staging of press required RN signatures, er		
		atement in a resident ct to a civil money penalty of			and found to be in complia		
		0 for each assessment.					
				3a.	re-in-serviced on 11/2/09 t	by the MDS	
	Clinical disagreemer and false statement.	nt does not constitute a material			coordinator on how to acci		
	and laise statement.		on the MDS. 3b. The MDS coordinator will coding compliance daily u				
	This REQUIREMEN	T is not met as evidenced by:			MDS/Care plan audit tool.	ang arc	
	five(5) of 26 sampled that facility staff faile Data Sets (MDS) for ulcers, one (1) reside resident for falls, one and range of motion			4.	Problems related to MDS or reported to the Administrat action and discussed in th Management and Quarterly	or for remedial e monthly Risk	11/27/(
	The findings include:						
	1. Facility staff failed for pressure ulcers.	to accurately code Resident #3			•		
	23, 2009 revealed th accurately code the s	#3' s quarterly MDS dated July at facility staff failed to stage of the resident's pressure The resident' s ulcer was on the MDS.					
		ubitus Report" dated July 20, Vound Nurse documents the					

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		AND HUMAN SERVICES <u>&amp; MEDICAID SERVICES</u>				M APPROVE <u>D. 0938-0</u> 39	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SI COMPLE	JRVEY	
		095031	B. WING		10/	13/2009	
	ROVIDER OR SUPPLIER	IG CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT		ULD BE CROSS-	(X5) COMPLETION DATE	
F 278	Continued From page	ge 9	F 278				
		d)-revealed that the pressure ed as a Stage Three.					
	Employee #7 at app October 13, 2009. I pressure ulcer was i	iew was conducted with roximately 11:00 AM on le/she acknowledged that the ncorrectly coded on the MDS. ewed on October 7, 2009.					
	[Number of Medicati	d to accurately code Section O1 ons] on the "Significant ssessment" MDS completed on sident # 4.					
	an "Interim Order Fe 18, 2009 and renew "Psych [Psychiatrist]	t # 4's clinical record revealed orm" dated and signed March ed on June 22, 2009 that directs order Haldol Dec. [Haldol M [Intramuscular] q [Every] nation"					
	revealed the residen Record [MAR] that in administered Haldol	ne resident's clinical record t's Medication Administration ndicated that the resident was on July 4, 2009 as evidenced from the entry for Haldol.					
	Assessment "MDS	nificant Change in Status completed on July 17, 2009 n O1 was coded as "zero" for nedications used					
	Employees # 6 and approximately 11:00 the coding was inacc administered outside not take into conside	ew was conducted with 13 on October 17, 2009 at AM. They acknowledged that curate. The medication was the look back window and did ration that the Haldol ng acting antipsychotic		· ·			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095031	B. WING	· · · · · · · · · · · · · · · · · · ·	10/1	3/2009
	ROVIDER OR SUPPLIER	SING CTR	1 :	REET ADDRESS, CITY, STATE, ZIP CC 2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(XS) COMPLETION DATE
F 278	Continued From p	page 10	F 278	R		
		ecord-was-reviewed-October-7,				
		led to accurately code the n Data Set for "Accidents" for				
	signed July 9, 200	arterly Minimum Data Set (MDS) 99 revealed Section J4 [Accidents], her fracture in the last 180 days."			· .	
	December 2008 th	nical record for the period of nrough July 2009 lacked evidence sustained a fracture.			• • •	
	Employee #9 on 0 10:30 AM. He/she inaccurately beca	erview was conducted with October 6, 2009 at approximately e stated that the MDS was coded use the resident had not sustained st 180 days from the July 2009			<i>ر</i>	
	Employee #13 on 3:50 PM. He/she a	erview was conducted with October 7, 2009 at approximately acknowledged the MDS was y. The record was reviewed				
	4. Facility staff fail admission MDS for	ed to sign Section R2 on the r Resident #15.				
	revealed that Sec	DS completed March 2, 2009 tion R2, "Signature of Person Assessment" was blank.				
	212, "Federal regu	IDS 2.0 User's Manual, page 3- ilations require the RN inator to sign and thereby				

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Facility ID: ROCKCREEK

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STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NC (X3) DATE SL COMPLE	). 0938-03 RVEY TED
		095031	B. WING		10/1	3/2009
	ROVIDER OR SUPPLIER	NG CTR	21	ET ADDRESS, CITY, STATE, ZIP CODE 31 O STREET NW ASHINGTON, DC 20037		572005
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETIC DATE
F 278	Continued From pa	ge 11	F 278			
·	-certify-that-the-asse	essment-is-completed:"				·
	Employee # 9 on O He/she acknowledg	view was conducted with ctober 9, 2009 at 3:30 PM. ged that Section R2 was not coordinator. The record was 009.				
	revealed facility star significant change f intake. Additionally,	clinical record for Resident #22 ff failed to accurately code the MDS for parenteral/enteral the annual and significant inaccurately coded for motion.				
:	signed February 8, included aphasia, d failure, contractures	tory and physical examination 2009, Resident #22's diagnoses ysphagia, dementia, renal , anoxic encephalopathy, arthritis and deep vein		 		
	July 3, 2009 revealed	Significant Change MDS signed ed Section K, Oral/Nutritional s 51-75% of total daily calories edings.		·		
	1.2 calories via gas hour for 18 hours vi Medication Adminis	d July 1, 2009 directed "Jevity trostomy tube @ 55 milliliters per a pump." According to the tration Record for July 2009, the administered during the time 10:00 AM daily.				
	Employee #16 on O	view was conducted with october 9, 2009 at approximately nse to a query regarding ritional status		·		•

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE S	
	A CORRECTION	IDENTIFICATION NONDER.	A. BUILDING		COMPLE	ITED
		095031	B. WING		10/	13/2009
	ROVIDER OR SUPPLIER	NG CTR	213	ET ADDRESS, CITY, STATE, ZIP CO 11 O STREET NW ASHINGTON, DC 20037	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	IO PREFIX. TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION ) REFERENCED TO THE APPROI	SHOULD BE CROSS-	(X5) COMPLETIC DATE
F 278	Continued From pa	age 12	F 278		·	
	mouth and enteral	esident-receives-nothing-by feedings are administered via ly to meet his/her hydration and				
	coded inaccurately	nowledged that the MDS was and that 100% of the resident's was received enterally.				
	3-109/110, Function Motion, Code "0" function range of m movement. Code " the body and/or par	MDS 2.0 User's Manual, page nal Limitation in Range of for no limitation, resident has full totion and/or voluntary 1" for limitation on one side of rtial loss of voluntary movement. ions on both sides of the body poluntary movement.				
	3, 2009 and the An revealed Section G	nificant Change MDS signed July nual MDS signed April 4, 2009 4, Functional Limitation in Range ed as "00 - no limitations."				
	June 30, 2009 reve	abilitation assessment dated aled Resident #22 was totally lity and self care and unable to y.		·		
	Employee #16 on C 11:00 AM. In respo Resident #22's func- the resident was ad totally dependent a	view was conducted with October 9, 2009 at approximately onse to a query regarding ctional ability, he/she stated that Imitted January 2009 and was t the time of admission. He/she nove independently. Hand and olied				
IRM CMS-256	57(02-99) Previous Versions (	Dbsolete Event ID: 2J6R11	Facility	y ID: ROCKCREEK	If continuation shee	t Page 13 of

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		& MEDICAID SERVICES			OMB_NO.	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		(X3) DATE SUR COMPLETE	
		095031	B. WING		10/13	/2009
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
ROCK CI	REEK MANOR NURSIN	IG CTR	2131 O STREET NW WASHINGTON, DC 20037			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROF	HOULD BE CROSS-	(X5) COMPLETI DATE
F 278			F 278			
	He/she acknowledg	per extremity contractures. ed the MDS lacked evidence of f voluntary movement. The d October 9, 2009.				
F 280 SS=D	CARE PLANS	D(k)(2) COMPREHENSIVE	F 280	<ol> <li>Care plans for reside were up-dated to ref status on 10/16/09.</li> </ol>		
	incompetent or othe under the laws of the	e right, unless adjudged rwise found to be incapacitated e State, to participate in eatment or changes in care and		2. All care plans were running 11/3/09 for updated to be in compliance.		
	within 7 days after the comprehensive asset interdisciplinary team physician, a register the resident, and oth disciplines as determ and, to the extent pro- the resident, the resi- legal representative;	are plan must be developed ne completion of the essment; prepared by an n, that includes the attending ed nurse with responsibility for ner appropriate staff in nined by the resident's needs, acticable, the participation of ident's family or the resident's and periodically reviewed and f qualified persons after each		<ul> <li>3a. The interdisciplinary were retrained on 10 importance of compupdating MDS/care care conference me</li> <li>3b. Medical records staf plans monthly to enupdated.</li> <li>4. Problems of not updated.</li> <li>4. Problems of not updated.</li> <li>4. Problems of not updated.</li> <li>4. Monthly Risk Manage Quarterly QA meeting</li> </ul>	0/23/09 on the oleting and plans after each eeting. If will audit care sure that they are ating care plans e DON, AA/QA for discussed in the ement/QA and	11/27/05
	This REQUIREMEN	T is not met as evidenced by:				
	interview of two (2) determined that facil revise care plans aft	on, record review and staff of 26 sampled residents, it was ity staff failed to review and er quarterly Minimum Data Set . Residents #4 and 13.				
	The findings include:	: · ·	ļ			1

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	. (X2) MU	JLTIPLE	CONSTRUCTION	(X3) DATE SU	D. 0938-039 JRVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING	·	COMPLE	
		095031	B. WIN	G		10/1	3/ <u>2</u> 009
IAME OF PI	ROVIDER OR SUPPLIER		}		ADDRESS, CITY, STATE, ZIP COD	DE	
ROCK CI	REEK MANOR NUR	SING CTR			O STREET NW SHINGTON, DC 20037		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETIO DATE	
F 280 Continued From page 14		page 14	F 2	80			
		t to review and revise multiple care ic assessments for Residents #4				· ·	
	revealed that he/s assessment comp	ew of Resident <b>#</b> 4 ' s clinical record I that he/she had a periodic quarterly nent completed on March 16, 2009 as ed by a signed and dated Minimum data DS)					
	revealed a "Care twenty-one active problems were ac September 2008 a December 22, 200 "Weight maintena "Abnormal Labs C updated/evaluated	f Resident # 4's clinical record Plan Problem List " that listed problems. Nineteen of the listed tive and initiated on or before and were all updated/evaluated on 08 and June 17, 2009. Problem #6 nce Care Plan"; and Problem #15 Care Plan " were d after the resident was assessed DS completed on March 16, 2009.					
	resident's followin resident was asse completed on Mar dental, fall preven constipation, psyc depression, self c compliance, allerg	to review and revise the g multiple care plans after the ssed and a quarterly MDS was ch 16, 2009: "Physical mobility, tion, hypertension, risk for hoactive drug use, agitation, are deficit, pain, delusion, non ty, territorial behavior, vision, hentia, dehydration and behavior-					
	Employee #6 on 0 11:00 AM. After re	erview was conducted with October 17, 2009 at approximately eviewing the resident's clinical knowledged the above findings.					

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Facility ID: ROCKCREEK

If continuation sheet Page 15 of 36

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SU COMPLET	
		095031	B. WING			10/1	3/2009
NAME OF PF	ROVIDER OR SUPPLIER	•	5	STREET	ADDRESS, CITY, STATE, Z		012005
ROCKC	REEK MANOR NURSH	NGCTR			OSTREET NW HINGTON, DC 20037	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIÉNCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE AC	N OF CORRECTION TION SHOULD BE CROSS- PROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page	ge 15	F 28	30			
·	-oversight."The-red 2009.	cord-was-reviewed October 7,					
	revealed that the realized tha	lent # 13's clinical record sident was accessed on March eptember 14, 2009 as evidenced ated respectively quarterly, y MDS.				·	
	revealed that the for not updated and rev resident was assess completed on March loss/dementia, psyc deficit, vision, incom 9+ medication, diabo	he resident 's clinical record llowing multiple care plans were ised /evaluated after the sed and a quarterly MDS in 19, 2009. "Cognitive hoactive drug use, self care inence, fall prevention, dental, etes, allergy, dehydration risk, oagulation, seizure disorder, er. "					- - - - -
	#13's multiple active	e review and revise Resident care plans after the resident a quarterly MDS completed on					
	Employee # 6 on Oc 3:40 PM. After revier record, he/she ackne	iew was conducted with tober 17, 2009 at approximately wing the resident's clinical owledged the above findings. as an oversight." The record er 7, 2009.					
F 281 SS=D		PREHENSIVE CARE PLANS	F 28	1 1a.	Resident #K1 wa deficient practice	s not harmed by the	
}		ed or arranged by the facility nal standards of quality.		1b.	The resident's ap	ical pulse was 09 and found to be	
	This REQUIREMEN	T is not met as evidenced			1		
M CMS-256	7(02-99) Previous Versions OI	Dosolete Event ID: 2J6R11		Eacility ID	ROCKCREEK	If continuation sheet	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVI COMPLETED	EY
		095031	B. WING		10/12/	2000
NAME OF P				TREET ADDRESS, CITY, STATE, ZIP CODE	10/13/2	2009
				2131 O STREET NW		
ROCKCI	REEK MANOR NURS	SINGCIR		WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETIC DATE
F 281	· · · · · · · · · · · · · · · · · ·	page 16	F 28	IC. THE ICENSED STAIL WAS		
	conducted on Oct and 8:30 AM, it wa	ations during the medication pass ober 8, 2009 between 8:00 AM as determined licensed staff failed	anna a sharan a shara	10/24/09 on the import apical pulse before the of Digoxin.	ance of checking administration	
	administration of a	ents' apical pulse prior to the an antiarrhythmic medication in ication pass opportunities.		<ol> <li>The MARs of all residents receiving Digoxin were reviewed on 10/30/09 for apical pulse documentation and found to be in compliance.</li> <li>Licensed staff were re-in-serviced on 10/30/09 on the importance of vital sign assessment before the administration of an antiarrhythmic medication.</li> <li>Random medication pass audit will be conducted with the charge nurses on a quarterly basis and PRN to ensure accuracy of medication administration.</li> </ol>		
	conducted on Octa and 8:30 AM on th that the nurse adm	de: ring the medication pass ober 8, 2009 between 8:00 AM ie 2nd floor nursing unit revealed hinistered an antiarrhythmic t assessing Resident K1's apical				
	physician's orders dated A directed "Digoxin 0.125m daily for congestive heart A review of the Medication	edication Administration Record revealed Digoxin was scheduled		<ol> <li>Problems related to the Medication administration to the DON unto the Ad remedial action and disc monthly Risk Managem Quarterly QA meetings.</li> </ol>	resident's on will be reported ministrator for cussed in the ent/QA and	11/27/09
	was observed prep one of which inclu- offered the resider medications. The r the nurse verified to medications. As the was queried regar	tion pass observation, the nurse paring Resident K1's medications, ded Digoxin 0.125 mg. He/she nt a cup of water and the resident swallowed the pills and that the resident swallowed the e resident departed, the nurse ding the resident 's vital signs. vital signs were not obtained.				
(	The nurse immedia	ately asked the resident to				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		095031	B. WING		10/13/2	P009
	ROVIDER OR SUPPLIER	ING CTR	2	REET ADDRESS, CITY, STATE, ZIP CODE 131 O STREET NW VASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETIC DATE
F 281	Continued From p	age 17	F 281			
	assessed. The nur resident ' s apical per minute. According to the g Reference Handbo 12th Edition, nursi administration of D pulse before giving The findings were Employee #6 durir October 8, 2009 at This deficiency has 483.25.	review and confirmed by ig a face-to-face interview on approximately 8:30 AM. is been cross referenced to CFR				
F 309 SS=D	provide the necess maintain the highe and psychosocial w comprehensive as: This REQUIREME Based on observat review for one (1) of (1) of 26 supplement that rehabilitation s	DF CARE t receive and the facility must ary care and services to attain or st practicable physical, mental, vell-being, in accordance with the sessment and plan of care. NT is not met as evidenced by: ion, staff interview and record of 26 sampled residents, and one ntal residents, it was determined ervices failed to follow-up on a or therapy for one (1) resident	F 309	<ol> <li>The facility clarified that not on hospice care.</li> <li>The resident was re-scree 10/12/09 and admitted for ST.</li> <li>All other resident physic were reviewed on 11/5// rehabilitation services a compliance.</li> <li>A weekly chart audit will by the RCC to ensure the rehabilitation services a physician's orders.</li> <li>Licensed staff will be in-standard to ensure 11/6/09 on the importance</li> </ol>	eened on or PT, OT and tian orders 09 for nd found to be in be conducted hat orders for re done per serviced on the of reviewing	
	and licensed staff f apical pulse prior to	ailed to assess a residents' o the administration of an lication in one (1) of 42		physician orders to ensu orders for rehabilitation s followed-up in a timely m	ervices are	

TATEMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				(X3) DATE SI COMPLE	
		095031	B. WING				10/*	13/2009
	ROVIDER OR SUPPLIER	IG CTR	S	2131	O STREE	, CITY, STATE, ZIP CODE ET NW DN, DC 20037	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		F (EACH C	PROVIDER'S PLAN OF CC CORRECTIVE ACTION SH NCED TO THE APPROPR	IOULD BE CROSS-	(X5) COMPLETION DATE
F 309	Continued From page	ge 18	F 30	)9 4	. Deficie	ent practice relate	ed to rehab	
·	-Residents-#1-and-	<1		=		es and physician		
	The findings include				Admin discus	ed to the DON un histrator for remed sed in the month	lial action and ly Risk	
	1. Facility staff faile order for rehabilitation	d to follow-up on a physician's on services for Resident #11.			Manaç meetir	gement/QA and C ngs.	luarterly QA	11/27/09
	the "Admission Ord Care" dated July 7,	t record revealed an order on ler Sheet and Physician Plan of 2009 that read, "Screen: Ind Occupational Therapy".						•
	Screen Sheet" revea	erdisciplinary Resident Rehab aled a note dated July 21, 2009 currently on hospice Patient not						
	8:00 PM reads. "Re care. According to h opted for hospice ca physician] holds a d	on note dated July 20, 2009 at sident is admitted for palliative ospital papers the family has the however [attending ifferent view. Resident care up with [attending physician]. "						
	A review of resident resident being admi	record revealed no record of ted to hospice care at facility.						
	Employee #30 on O He/she stated that r admission but becau	iew was conducted with ctober 8, 2009 at 2:15 PM. esident was screen on use he/she was hospice he/she ididate. The record was 2009.					:	
	2. Facility staff failed to administering Dig	I to obtain an apical pulse prior oxin for Resident K1.						
	An observation duri	ng the medication pass						

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				APPROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095031	B. WING		10/1	3/2009
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		012005
ROCK CI	REEK MANOR NURSIN	IG CTR		2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETION DATE
F 309			F 30			· · ·
	and 8:30 AM on the that the nurse admin medication without a pulse. A review of Residem physician's orders da directed " Digoxin 0 daily for congestive I A review of the Medi for October 2009 rev for administration at During the medication was observed prepa one of which include offered the resident a medications. The res the nurse verified tha medications. As the was queried regardin He/she stated that vi The nurse immediate to his/her room so th	cation Administration Record realed Digoxin was scheduled		<ul> <li>deficient practice.</li> <li>1b. The resident's apical pull checked on 10/9/09 and within normal range.</li> <li>1c. The licensed staff was re 10/24/09 on the importar checking apical pulse be administration of Digoxi</li> <li>2. The MARs of all resident: Digoxin were reviewed for documentation and foun compliance by 10/30/09.</li> <li>3a. Licensed staff were re-in 10/30/09 on appropriate monitoring during medica administration (Digoxin).</li> <li>3b. Random medication pas conducted with the charg a quarterly basis and PR accuracy in medication at the compliance of the charge a diministration will be rep DON unto the Administration.</li> </ul>	se was found to be trained on nee of efore the n. s receiving or apical pulse d to be in -serviced on vital sign ation s audit will be ge nurses on N to ensure idministration. lication	
		esult was 82 beats per minute. been cross referenced to CFR		remedial action and disc monthly Risk Manageme Quarterly QA meetings.	nt/QA and	11/27/09
F 311 SS=D	A resident is given the services to maintain	TIES OF DAILY LIVING the appropriate treatment and or improve his or her abilities wh (a)(1) of this section.	F 31	1		

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Facility ID: ROCKCREEK

If continuation sheet Page 20 of 36

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SU COMPLE		
		095031	B. WING		10/1	3/2009	
	ROVIDER OR SUPPLIER	IG CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE	
F 311	Continued From pag	ge 20	F 31	1 ==1a:=Resident=#5=was=refi	erred-to-rehab		
	This REQUIREMEN	T is not met as evidenced by:		services for screenir for a decreased ROI	ig and evaluation		
	(1) of 26 sampled re facility staff failed to			<ol> <li>Resident #5 was address rehabilitation therapy</li> <li>Quarterly MDS assereviewed for decline motion on 11/5/09 and in compliance.</li> </ol>	y on 10/15/09. ssments were in range of		
	service to maintain a Range of Motion to I A review of the Minit following: The quart 2009 Section G4 [Te hand was coded as movement; The qua 2009 and the annua 14, 2009 Section G4 on one side and par The record lacked d rehabilitative and/or provided to Residen limitation in range of assessed/identified. A face-to-face interv 13, 2009 at 9:15 AM acknowledged that f rehabilitative and/or noted decline in the	mum Data Sets revealed the erly MDS completed March 27, est for Balance] Neck, Arm and no limitation or voluntary rterly MDS completed June 22, MDS completed September Neck was coded as Limitation tial loss.		<ul> <li>3a. The RCC will audit of ADL flow sheets and to ensure that any sidecrease in a reside referred to rehabilitat screening.</li> <li>3b. A weekly audit of the will be conducted by ensure that all physic followed.</li> <li>3c. Residents will be screehabilitation depart during their assession.</li> <li>4. Problems related to services and physic reported to the DON Administrator for rer discussed in the mom Management/QA armeetings.</li> </ul>	d MDS quarterly ignificant ents' ADLs is ation for e resident's chart y the RCCs to ician orders are reened by the ment quarterly nent period. rehabilitation ian orders will be I unto the medial action and onthly Risk ad Quarterly QA	11/27/09	

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Facility ID: ROCKCREEK

If continuation sheet Page 21 of 36

	RS FOR MEDICARE	& MEDICAID SERVICES			FORM A <u>OMB NO. 0</u> (X3) DATE SURVE	938-03
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED	T
		095031	B. WING	<u>_</u>	10/13/2	009
	ROVIDER OR SUPPLIER	NG CTR		REET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIJ	ULD BE CROSS-	(XS) COMPLE DATE
F 323		NTS AND SUPERVISION	F 323	I. THE FILE EXUITYUISHEL IOU	cated in the	
99 <b>-</b> D:	The facility must en environment remain	sure that the resident hs as free of accident hazards as ch resident receives adequate		rehabilitation service off mounted on the wall on		
		sistance devices to prevent		<ol> <li>Fire extinguishers throug have been checked on 1 Director of Maintenance in compliance.</li> </ol>	0/8/09 by the	
	This REQUIREMEN	IT is not met as evidenced by:		<ol> <li>Fire extinguishers will be during Grand Rounds by Maintenance for continu</li> </ol>	the Director of	
	rehabilitation area, i failed to ensure that free from accident h extinguisher was sto area and a compute	ons made during a tour of the it was determined that the facility the residents environment was nazards as evidenced by a fire ored unsecure in the resident er monitor was stored on the y. These observations were ce of Employee #30.		<ol> <li>Deficient practices relatin extinguishers will be repo- unto the Administrator for and discussed in the mor Management/QA and Qu meetings.</li> </ol>	rted to the DON remedial action othly Risk	11/27/
	The findings include	e:				
	table in the treatment	er was stored unsecured on a nt area in one (1) of one (1) fire ed in the rehabilitation area.				I
		nitor was stored directly on the y located across from the floor.				
	These findings were #30 at the time of th	e acknowledged by Employee e observation.				
F 334 SS=E	483.25(n) INFLUEN IMMUNIZATION	ZA AND PNEUMOCOCCAL	F 334			
ļ	The facility must dev	velop policies and procedures			· · · · · · · · · · · · · · · · · · ·	

	OF DEFICIENCIES	<u>RE &amp; MEDICAID SERVICES</u>	(Y2) MIT		CONSTRUCTION	OMB NO. 0	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE SURVE COMPLETED	ΞY
		095031	B. WING	<u> </u>	<u></u>		2009
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROCK CI	REEK MANOR NUR	SING CTR			O STREET NW HINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	LD BE CROSS-	(X5) COMPLETIN DATE
F 323	483.25(h) ACCID	ENTS AND SUPERVISION	F 32	23 1.	The Computer monitor that	at was found on	
<del>SS=</del> D-	environment remains possible; and e	ensure that the resident ains as free of accident hazards as ach resident receives adequate			the 6 <sup>th</sup> floor rehabilitation removed on 10/9/09 for a storage.	area was	
	accidents.	ssistance devices to prevent		2.	No other unused compute present in the rehabilitatio		
		ENT is not met as evidenced by: ations made during a tour of the			<ul> <li>Director of Rehabilitation s in-serviced staff on proper hazardous items on 10/29</li> <li>Director of Rehabilitation conduct weekly rounds for</li> </ul>	r disposal of 1/09. services will	
	rehabilitation area failed to ensure the free from accident extinguisher was area and a compu- heater in the hallw	a, it was determined that the facility that the residents environment was t hazards as evidenced by a fire stored unsecure in the resident ther monitor was stored on the way. These observations were ence of Employee #30.		4.	compliance. Deficient practices related disposal of old computers to the Administrator for re- and discussed in the mon- Management/QA and Qua- meetings.	will be reported medial action thly Risk	11/27/0
	The findings inclu	de:			-		
	table in the treatm	her was stored unsecured on a lent area in one (1) of one (1) fire rved in the rehabilitation area.					
		onitor was stored directly on the vay located across from the th floor.					
	These findings we #30 at the time of	re acknowledged by Employee the observation.	·				
F 334 SS=E	483.25(n) INFLUE IMMUNIZATION	NZA AND PNEUMOCOCCAL	F 33	4			•
	The facility must d	levelop policies and procedures					

PRINTED: 10/27/2009

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDING			(X3) DATE SURVE COMPLETED	ΞY
		095031	B. WING			10/13/2	2009
IAME OF PR			STF	REET	ADDRESS, CITY, STATE, ZIP CODE		
ROCKC	REEK MANOR NURSI	NGCTR			O STREET NW HINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE
	· · · · · · · · · · · · · · · · · · ·			_			DATE
F 334	Continued From pa	ge 22	F 334	1a.	Residents #2,3,7,8,11,12,15		
	that ensures that				F4,F5,F6,F7,F8,F9,F10,F11		
		ne influenza immunization, each			F14,F16,F17,F18,F19,F20,F		
		dent's legal representative			F23 have been offered PPD		
		regarding the benefits and			Pneumococcal vaccines an		
		s of the immunization;			record documentation reflect	ct their	
1		offered an influenza per 1 through March 31 annually,			wishes.		
	unless the immuniz			42		<b>1</b> .	
		he resident has already been		10.	The facility's immunization		
	immunized during th	, , , , , , , , , , , , , , , , , , , ,			revised on 10/14/09 to emp		
	(iii) The resident or			ſ	residents'/responsible party		
		the opportunity to refuse			acceptance or refusal of im	munization	
	immunization; and			1	(See attachment V).		
	(iv) The resident's n	nedical record includes		2	A abort audit for ather reaid	 	
{	documentation that	indicates, at a minimum, the		Z.'	A chart audit for other reside conducted on 10/14/09 and		
	following:						
		ent or resident's legal			the immunization acceptance		
		provided education regarding			by residents/responsible par	ties were	
	the benefits and pol immunization; and	tential side effects of influenza		)	documented by RCC and ch		
		ent either received the influenza		3a.	An in-service was offered to		
		not receive the influenza		ļ	and RN supervisors on 10/2		
	immunization due to	o medical contraindications or			them about consent forms a		
	refusal.			ļ	immunization policy and pro		
	man e sure e t			3b.	ADON who is an infection of		
(		velop policies and procedures			will monitor for compliance		
	that ensure that –	e pneumococcal immunization,		3c.	Monthly chart audit will be c		
•		e resident's legal representative			medical records staff to ens		
		regarding the benefits and		)	immunizations have been o		
		s of the immunization;			accepted or declined throug	h a written	
		offered a pneumococcal			consent.		
		s the immunization is medically		4	Problems related to residen	to l	
		ne resident has already been		4.	immunization and PPD skin		
,	immunized;				reported to the DON, the Ad		
ł	(iii) The resident or I				for remedial action and disci		
	representative has t	he opportunity to refuse		1	monthly Risk Management/		
					Quarterly QA meetings.		11/27/09
					GUALCHY GA HICKLINGS.		11////14

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Facility ID: ROCKCREEK .

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If continuation sheet Page 23 of 36

,		AND HUMAN SERVICES & MEDICAID SERVICES				M APPROVED D. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	(X3) DATE SI COMPLE	JRVEY		
		095031	8. WING		10/-	13/2009		
	ROVIDER OR SUPPLIER	IG CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETION DATE		
F 334	Continued From page		F 334		······			
	-immunization;-and (iv) The resident's m documentation that following: (A) That the reside representative was p the benefits and pot pneumococcal immu (B) That the reside pneumococcal immu contraindication or m (v) As an alternative practitioner recomm pneumococcal immu years following the fi immunization, unless	nedical record includes indicated, at a minimum, the ent or resident's legal provided education regarding ential side effects of unization; and nt either received the unization or did not receive the unization due to medical efusal. , based on an assessment and endation, a second unization may be given after 5 irst pneumococcal s medically contraindicated or esident's legal representative						
	This REQUIREMEN	T is not met as evidenced by:				;		
	of 26 sampled resider residents, it was deter failed to ensure that included documenta receive the influenza residents refusal/der 12, 15, 20, F2, F3, F	iew, staff interview for eight (8) ents and 22 supplemental ermined that the facility staff the resident's medical record tion that residents did not a immunization due to the hial. Residents #2, 3, 7, 8, 11, 4, F5, F6, F7, F8, F9, F10, F11, F16, F17, F18, F19, F20, F21,						
ļ	The findings include:	:						
	On October 9, 2009	at 11:09 AM, a review of the		· ·				

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Event ID: 2J6R11

Facility ID: ROCKCREEK

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ØEPAR	FMENT OF HEALTH	AND HUMAN SERVICES					10/27/2009 APPROVED
{     –     –		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SUR COMPLETE	
		095031	B. WIN	G		10/13	/2009
NAME OF PF	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ROCK CI	REEK MANOR NURSIN	IG CTR			1 O STREET NW ASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETION . DATE
F 334	Continued From page	je 24	F 3	334			+
	X-Ray Audits " [line the facility that recei immunization] was of there was no docum administration of Infl following Residents: F3, F4, F5, F6, F7, F F14, F15, F16, F17, F23. On October 9, 2009 face-to-face interview Employee #4. He/sh refusal or denial to h should have been do Consent Forms for In Vaccines and Tetand located in the reside #4 further reviewed to Protein Derivative], C of residents and ack records did not cons	ified Protein Derivative], Chest listing identifying all residents in ved and/or refused the influenza conducted and revealed that ented information regarding the uenza immunizations for the #2, 3, 7, 8, 11, 12, 15, 20 F2, 78, F9, F10, F11, F12, F13, F18, F19, F20, F21, F22, and at approximately 11:15 AM a w was conducted with he stated, "The resident's ave the Influenza vaccine bocumented on the " Resident influenza and Pneumococcal us -Diphtheria Toxoids " form int 's clinical record. Employee he " Vaccine, PPD [Punfied Chest X-Ray Audits " line listing nowledged that the medical istently contain documentation ccines had been refused/denied					
F 371 SS=E	considered satisfactor authorities; and	CONDITIONS n sources approved or bry by Federal, State or local istribute and serve food under	F 3	71			

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Event ID: 2J6R11

Facility IO: ROCKCREEK

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PRINTED: 10/27/2009

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURV COMPLETED	
		095031	B. WING			2009
	ROVIDER OR SUPPLIER	IG CTR	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOT REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETION DATE
F 371	Continued From page	ge 25	F 37			
	This REQUIREMEN	IT is not met as evidenced by:		— 2.—All-dietary-related equip checked on 10/14/09 fo were found to be in con	r cleanliness and	
	<ul> <li>9, 2009 during the todetermined that the distribute food underevidenced by a soile main dining room; a water leaking from thand hot food temper degrees Fahrenheit. made in the present of the findings include</li> <li>1. The outdoor grill s and was observed to one (1) of one (1) of cleaning in one (1) of the dishwashing area in</li> <li>4. A test tray was contact of the distribute of the distribut</li></ul>	stored in the main dining room b be soiled with food residue in utdoor grill observed. r was soiled and in need of of one (1) observation. Ig from the ceiling in the one (1) of one (1) observation.		<ul> <li>3a. In-service on how to proutdoor grill was given and therapeutic recreat 10/14/09.</li> <li>3b. The Director of Food S Director of Therapeutic conduct daily a overall outside grill for complia</li> <li>4. Problems relating to cle grill will be reported imm Administrator and discumonthly Risk Managem Quarterly QA meetings remedial action.</li> <li>1. The soiled floor in the kit cleaned on 10/6/09.</li> <li>2. Floor surfaces throughout were checked for cleanling found to be in compliant.</li> <li>3a. Dietary staff were re-in-10/19/09 on how to clean.</li> </ul>	to dietary tion staff on ervices and Recreation will cleanliness of the nce. aning the outside nediately to the ssed in the tent/QA and for further then was ut the kitchen ness and was ce on 10/14/09.	11/27/05
	approximately 1:00 I were less than the re following items:	<sup>o</sup> M. The hot food temperatures equired 140 degrees on the		floor. 3b. The food service Director daily and weekly cleanin ensure compliance.	or will conduct	
	Lima beans were 13 Green beans were 1	32 degrees F		3c. The facility will obtain pr assess the kitchen floor long-term renovation pl	r a part of a	
	These findings were #10 at the time obse	acknowledged by Employee rvation		<ol> <li>All problems relating to cleaning will be discussed Risk Management/QA a meetings for further rem</li> </ol>	ed in the monthly Ind Quarterly QA	

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		IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095031	B. WING	3 <u></u> _		10/13/	2009
	DVIDER OR SUPPLIER	IG CTR		2131 0 5	DRESS, CITY, STATE, ZIP CO STREET NW NGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS)	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	, (C	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTION S FERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETION DATE
F 371	Continued From page	je 25	F 3	1. V	later leak in the kitch		
	This REQUIREMEN	IT is not met as evidenced by:			t dish machine area 0/8/09.	was resolved on	
	9, 2009 during the to determined that the	ons made on October 6 through our of dietary services, it was facility failed to prepare and r sanitary conditions as		( E	The facility was chec Director of Maintenar In compliance on 10/6	nce and found to be	
	evidenced by a soile main dining room; a water leaking from tl and hot food temper	ed outdoor grill stored in the soiled floor in the main kitchen; he ceiling in the main kitchen; atures were less than 140 These observations were		a k N	Vater leaks from the irea will be checked itchen Rounds by th Aaintenance and Foo or continued complia	daily during AM e Director of od Service Director	
	and was observed to one (1) of one (1) ou	stored in the main dining room b be soiled with food residue in utdoor grill observed.		wi of re M	eficient practices rela II be reported immed Maintenance unto the medial action and d lanagement/QA and leetings.	liately to the director ne Administrator for iscussed in the Risk	
		r was soiled and in need of of one (1) observation.					
		g from the ceiling in the one (1) of one (1) observation.					
	approximately 1:00 I	onducted on October 9, 2009 at PM. The hot food temperatures equired 140 degrees on the					
Fri Lir Gr Th	Fried Catfish was 12 Lima beans were 13 Green beans were 1		·				
	These findings were #10 at the time obse	acknowledged by Employee . rvation.					

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1			AND HUMAN SERVICES & MEDICAID SERVICES			*	PRINTED: FORM A OM <u>B NO.</u> 0	PPROVED
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL			(X3) DATE SURVE COMPLETED	
			095031	B. WIN	G		10/13/2	2009
	NAME OF P	ROVIDER OR SUPPLIER	<u></u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	ROCK CI	REEK MANOR NURSIN	IG CTR			131 O STREET NW VASHINGTON, DC 20037		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS-	(X5) COMPLETION DATE
	F 371	Continued From page	ge 25	F	371	1a. Resident was not harmed by	the deficient	
		Based on observation 9, 2009 during the to determined that the distribute food under evidenced by a soiler main dining room; a water leaking from the and hot food temper degrees Fahrenheit, made in the presence The findings include 1. The outdoor grill s and was observed to one (1) of one (1) ou 2. The kitchen floor cleaning in one (1) of 3. Water was leaking dishwashing area in 4. A test tray was co approximately 1:00 f were less than the re following items: Fried Catfish was 12 Lima beans were 13 Green beans were 1	stored in the main dining room o be soiled with food residue in utdoor grill observed. In was soiled and in need of of one (1) observation. Ing from the ceiling in the one (1) of one (1) observation. Inducted on October 9, 2009 at PM. The hot food temperatures equired 140 degrees on the 24 degrees F (Fahrenheit) 10 degrees F 32 degrees F acknowledged by Employee			<ul> <li>practice.</li> <li>1b. Food for the affected residen reheated.</li> <li>2. Residents' food temperature on the unit on 10/14/09 and for in compliance with temperatu equal or greater than140°F for 3a. Food temperature will be moweekly to assure correct tem when they arrive on the unit.</li> <li>3b. Both nursing and Dietary stat in-serviced on 10/21/09 on the serving food temperatures or reheating of foods as needed 3c. Elevator #3 will be on reservent times to ensure a quick meal to the units.</li> <li>3d. Testing for adequate food terr will be conducted daily by the Service Director on the test to an unit.</li> <li>4. Problems relating to temperature arriving on unit will be reported to ADON, and discussed in momentary and Quarterly Quarterly Quarter for further remedial action.</li> </ul>	was checked ound to be re range of r hot food. nitored perature ff were he correct n unit and the delivery mperatures Food ray on the ure of food immediately onthly Risk A meetings	

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Facility ID; ROCKCREEK

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SUR	
NU PLAN UP	- CDRRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPLETE	Đ
		095031	B. WING	·	10/13	/2009
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ROCKCE	REEK MANOR NURSIN			2131 O STREET NW		
				WASHINGTON, DC 20037	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC	N OF CORRECTION TION SHOULD BE CROSS- PPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	483.60(b), (d), (e) P	HARMACY SERVICES	F 43	31 1a. The Xalatan eye	drops was discarded	 
SS=D-				and a new bottle of	of Xalatan eye drops	
		ploy or obtain the services of a		was obtained and		]
		who establishes a system of nd disposition of all controlled		1b. Resident #F1 was	s not harmed by the	
		etail to enable an accurate		deficient practice.		.
	reconciliation; and d	etermines that drug records are		2 RCCs checked all	residents' medication	
		account of all controlled drugs			is and found them to	
	is maintained and pe	eriodically reconciled.			with dating of opened	
ĺ	Developed this last a			vials on 10/30/09.	and adding of openiod	
		Is used in the facility must be contract the second s				
		es, and include the appropriate		3a. A weekly check of		
•		onary instructions, and the			clude eye drops will	
	expiration date when				the RCCs to ensure	ļ
					ns are labeled and	
		State and Federal laws, the		guidelines.	nd per manufactures	
{		drugs and biologicals in locked			ses were re-in-serviced	
		orized personnel to have		on 10/23/09 on th		
	access to the keys.			administration of medication.		
	The facility must pro	vide separately locked,				1
		compartments for storage of		4. Problems relating		
1	9	ed in Schedule II of the			n of medication will be	
		g Abuse Prevention and Control er drugs subject to abuse,			unto the Administrator	1
		ility uses single unit package			n and discussed in the nagement/QA and	
	drug distribution sys	tems in which the quantity		Quarterly QA mee		11/27/09
	stored is minimal an	d a missing dose can be readily		Guartery Grine	cungo.	1112/109
{	detected.					1
	This REQUIREMEN	T is not met as evidenced by:				
[		.				
ļ						
	Based on observatio	n and staff interview, it was				
		facility staff failed to properly				

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

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STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	'EY
095031		A. BUILDING	·			
	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	10/13/	2009
	REEK MANOR NURSIN	GCTR	21	ASHINGTON, DC 20037	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLET DATE
F 431	Continued From pag	je 27	F 431			
	store one(1) of one ( in accordance with t specifications.	(1) bottle of Xalatan medication he manufacturer's				
	The findings include	:			,	
	Xalatan, "Once a	nufactures specifications for bottle is opened for use, it may mperature up to 25 degrees C to 6 weeks."				
	during the inspectior	at approximately 3:50 PM of the medication cart, one (1) atan solution was observed in out an open date.				
	observation with Em to determine how lor	iew conducted at the time of the ployee #27. He/she was unable ng the bottle of Xalatan had acknowledged that the Xalatan when opened.				
F 454 SS=E	equipped, and maint	ENVIRONMENT designed, constructed, ained to protect the health and personnel and the public.	F 454	<ol> <li>Exhaust vents in reside 119,120,218,219,221,3 420,517,518, and 520 service on 10/10/09.</li> </ol>	19,320,417,419, were restored to	
		T is not met as evidenced by:		<ol> <li>Exhaust vents through have been checked by Maintenance and found compliance.</li> </ol>	the Director of	
	7, 2009, it was detern properly maintain the required as evidence not functioning prope	ns made during an f the facility on October 6 and mined that the facility failed to e physical environment as ed by 14 of 50 exhaust vents erly in resident rooms. The lade in the presence of		3. Exhaust vents will be c weekly during Grand R Director of Maintenanc compliance.	ounds by the	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	нт	IPLE CONSTRUCTION	(X3) DATE SURVE	<u>938-0391</u> •
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		095031	B, WIN	G _		10/13/2	2009
AME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROCK CI	REEK MANOR NURSIN	GCTR			2131 O STREET NW WASHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 454	Continued From pag	ie 28	F۷	454		,	
	The findings include				=-4Deficient-practices-relating-t vents will be reported immer Director of Maintenance unt	diately to the	
	in residents rooms of 14 of 50 resident rooms	s were observed not functioning on the west side of the facility in oms observed. Rooms #117, 221, 319, 320, 417, 419, 420,			Administrator for remedial a discussed in the monthly Ris Management/QA and Quart meetings.	sk	11/27/09
	The findings were ac at the time of the ob	knowledged by Employee #12 servations.					
F 469 SS=F	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control		F 4		<ul> <li>1a. The 5<sup>th</sup> floor nursing station for pest control on 10/19/09 Western Pest Company.</li> <li>1b. All nursing stations were tree</li> </ul>	by the	
		facility is free of pests and			<ol> <li>10/19/09 and found to be in</li> <li>The entire facility was check and treated for pest control</li> </ol>	ked	
	This REQUIREMEN	T is not met as evidenced by:			3a. Facility staff were in-service 10/24/09 to report pest cont		
	facility failed to main evidenced by flying p	, it was determined that the tain a pest free environment as best observed throughout the wling pests observed on one	<ul> <li>10/24/09 to report pest control issue in the pest control log book.</li> <li>3b. Compliance meeting was held with supervisor from the Western Pest Company on 11/3/09 on plans to c pest in the entire facility (See attachment V I).</li> </ul>	eld with the n Pest			
	The findings include				3. Problems relating to Pest C report to the Director of En		
		e observed throughout the he five (5) day recertification			Services unto the Administ remedial action and discus the monthly Risk Managem	rator for sed in	
	was determined facil	e (5) nursing units observed, it ity staff failed to maintain a pest evidenced by the presence of			Quarterly QA meetings.		11/27/09

PRINTED: 10/27/2009

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURV COMPLETED	
		095031	B. WING		10/13/	2009
	ROVIDER OR SUPPLIER	IG CTR	[	TREET ADDRESS, CITY, S 2131 O STREET NW WASHINGTON, DC	ITATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC	R'S PLAN OF CORRECTION TIVE ACTION SHOULD BE CROSS- D THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 469	Continued From page	ge 29	F 469	9		
	crawling pest was o floor nurses' station On Wednesday, Oc	tober 7, 2009 at 2:30 PM a was observed on the 5th floor				
F 492 SS=E	Employee #9. 483.75(b) ADMINIS The facility must ope compliance with all a local laws, regulation accepted profession	ade in the presence of TRATION erate and provide services in applicable Federal, State, and ns, and codes, and with al standards and principles that Is providing services in such a	F 492	examination was later fo on 10/13/09 2. All other res	sidents' charts were checked nd found to have up to date	
	Based on record rev (1) of 26 sampled re facility staff failed to comprehensive med for Resident #12. The findings include A review of Residen evidence of an annu examination for 2009 last comprehensive on June 24, 2008.	t #12's clinical record lacked al comprehensive medical 9. The record revealed that the medical examination was done iew was conducted with		<ul> <li>RCCs to endone in a tirdone in anner.</li> <li>3c. Medical recorresidents' considents' considents' considents' considents' considents' considents' considents' consident practical discussed in a tirdone in</li></ul>	hart audit will be done by the sure that residents' H&Ps are mely manner. bund to be nearing their date or at their annual due flagged by RCCs and the visician will be notified so that t&P can be done in a timely cords technicians will audit charts monthly for compliance actice related to annual H&P rted to the DON unto the pr for remedial action and in the monthly Risk ht/QA and Quarterly QA	

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If continuation sheet Page 30 of 36

		& MEDICAID SERVICES				OMB NO. C	PPROVED 938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		095031	B. WING			10/13/2	2009
		, AG CTR	S	2131 0	DDRESS, CITY, STATE, ZIP CODE STREET NW IINGTON, DC 20037	10/13/2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 492	Continued From page	ge 30	 F 49	2			
	October 8, 2009. H resident has not rec	e/she acknowledged that the eived a comprehensive physical d was reviewed on October 7,					
F 514 SS=D	resident in accordar	AL RECORDS intain clinical records on each ice with accepted professional ices that are complete;	F 51		Resident #1 was re-assess dehydration on 10/29/09. Resident showed weight in Assessment dated 10/29/0	crease in	
	accurately documen systematically organ The clinical record n	ited; readily accessible; and nized. nust contain sufficient		2:	All other residents at risk for were assessed by the RCC using dehydration assess found to be in compliance.	Cs on 11/3/09 nent tool and	
	resident's assessme services provided; th	fy the resident; a record of the ents; the plan of care and ne results of any preadmission d by the State; and progress		3.	All residents will be assess 3 months, during status cha admission for risk for dehyd	ange, and on	
		T is not met as evidenced by:		4.	Problems related to resider dehydration will be reported DON, Administrator and dis	d to the scussed	
Based on record (3) of 26 sampled facility staff failed and accurately do assessment for o one (1) resident for interventions and as it relates to sig	(3) of 26 sampled re facility staff failed to and accurately docu assessment for one one (1) resident for interventions and ac	view and staff interview for three sidents, it was determined transcribe diet texture orders ment a quarterly dehydration (1) resident; accurately screen mental illness and document curately revise the plan of care icant weight loss for one (1) #1,12 and 14.			in the monthly Risk Manage and Quarterly QA meetings remedial action		11/27/09
	The findings include	:					
	revealed facility staf	nical record for Resident #1 failed to accurately document ion assessment and transcribe nto the current					

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Facility ID: ROCKCREEK

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PRINTED: 10/27/2009
FORM APPROVED

ULNILI	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0	) <u>938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE	CONSTRUCTION	RUCTION (X3) DATE SURV COMPLETED	
			A. BUIL	DING			
		095031	B. WIN	S		10/13/2	2009
NAME OF PF	ROVIDER OR SUPPLIER	· ·	I	STREE	T ADDRESS, CITY, STATE, ZIP CODE	10/13/	2005
ROCK CF	REEK MANOR NURSIN	IG CTR		213	1 O STREET NW SHINGTON, DC 20037		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F 514	Continued From pag	je 31	F 5	514 1	. The Physician's order for d	iet texture for	
	Set (MDS) signed M K3 - weight change; "weight loss." The re documented as 123 quarterly MDS signe Section K3-weight cl as "weight loss" with pounds. A review of physician 15, 22nd, and Augus had poor oral intake declined. A review of the quart Assessment " revea March, June and Se labeled "refusal to ea	ignificant change Minimum Data arch 13, 2009 revealed, Section Resident #1 was coded as esident's weight was pounds. The subsequent d June 26, 2009 revealed hange; Resident #1 was coded in a documented weight of 116 h's progress notes dated July st 5, 2009 revealed the resident and his/her weight had terly "Dehydration Risk led assessment dates included ptember 2009. In the category at or eating significantly less ht ", a zero with a line through it		3	<ul> <li>Resident #1 (mech soft die transcribed to current phys 10/29/09.</li> <li>All physician orders for residiet were reviewed by the f 11/3/09 and found to be in</li> <li>a. RCC will review physician of monthly turnovers to ensure physicians order.</li> <li>b. All residents will be assessible JDT members during ID proper transcription of order</li> <li>Problems relating to physic orders will be reported to the Administrator for remedial a discussed in the monthly R</li> </ul>	dents' RCCs on compliance. orders during e accuracy in ed quarterly F to ensure rs. ian dietary e DON, the action and	
	not occur. The categ allocated for "sudder during the past mont .(did not occur). A face-to-face intervi Employee #9 on Oct 2:30 PM. In response accuracy of the Dehy he/she acknowledge inaccurate and failed oral intake decline.	dicating this characteristic did ory of the assessment in weight loss (5% or more h)", was documented as "0" ew was conducted with ober 6, 2009 at approximately e to a query regarding the ydration Risk Assessment, d that the assessment was I to capture the weight loss and			Management/QA and Quar meetings.	terly QA	11/27/09
		ost current physician's orders 09 revealed a therapeutic diet um, 2-3 gram	•				

*		AND HUMAN SERVICES			FORM A	10/27/2009 PPROVEC
STATEMENT (	S FOR MEDICARE DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SURV COMPLETED	EY
		095031	B. WING		10/13/2	2009
	OVIDER OR SUPPLIER	NG CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037		2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
	diet texture. The record reveale physician June 24, recommended for c mechanical soft, thi A face-to-face inter Employee #9 on Oc 2:30 PM. He/she ac failed to transcribe physician's orders. evidence that the re soft diet as ordered October 6, 2009. 2. Facility staff faile #12 for mental illne result of the screen A review of the Eva Illness/Mental Reta facility staff's docum the question "Does illness? " was inacc A review of the ann dated August 18, 20 revealed that the re Schizophrenia unde of both Minimum Da A review of the Inter Care Plans last upd revealed that the re	The order lacked evidence of a d an interim order signed by the 2009 that read, "treatment dysphagiachange diet to in liquids." view was conducted with ctober 6, 2009 at approximately cknowledged that facility staff the diet texture onto the current However, he/she provided esident received the mechanical . The record was reviewed d to accurately screen Resident ss and document the correct ing on the evaluation form. luation Critena for Mental redation of "no" in response to the client have a major mental curate. ual Minimum Data Sets (MDS) 008 and September 28, 2009 sident was coded for er section I (Disease Diagnoses)	F 5 <sup>-</sup>	<ul> <li>14</li> <li>1a: Resident #12 was not findeficient practice.</li> <li>1b. The MI/MR for the affee completed accurately or reflect his current menn diagnosis.</li> <li>2. All MI/MRs will be revial audited by Social Work to ensure that they reforesidents mental healt</li> <li>3. The Social Services contensure that information MI/MR are accurate a</li> <li>4. Problems related to the completion of the MI/MF reported to the Administ discussed in the monthly Management/QA and Q meetings for remedial and the second the second the second the second the second the second the monthly management/QA and Q meetings for remedial and the second the monthly management/QA and Q meetings for remedial and the second the second</li></ul>	ected resident was on 10/13/09 to tal health ewed and kers on11/18/09 lect each h diagnosis. onsultant retrained n 10/30/09 to n contained in the nd up-to-date. accurate R will be trator and y Risk uarterly QA	

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STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	OMB NO. 0 (X3) DATE SURVE COMPLETED	
		095031	B. WING		10/13/2	2009
		NG CTR ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY	2	REET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037 PROVIDER'S PLAN OF CORF	RECTION	(X5)
TAG		ENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIA	ILD BE CROSS- TE DEFICIENCY)	DATE
F 514	Continued From page	ge 33	F 514			
	Employee #17 at ap October 13, 2009. documentation of th screening on the even The record was revi 3. A review of the cli revealed facility staf interventions when i sustained an unplan sustained a decline Additionally, facility st the resident 's care unplanned weight lo According to the mo #14's weight was as months of March and June 2009; 124 pour pounds in September the resident occasio weight assessed and the months of Janua 2009. a.) According to the (MDS) signed Augus change, Resident #1 A nutritional progres revealed the residen (unplanned) weight I	view was conducted with oproximately 1:45 PM on He/she acknowledged that the e resident 's mental illness aluation form was inaccurate. ewed on October 7, 2009. inical record for Resident #14 f failed to document nutritional t was determined the resident in difficant weight loss and in nutritional/oral intake. staff failed to accurately revise plan to address the significant, ss sustained by the resident. nthly weight record, Resident sessed at 140 pounds for the d April 2009; 138 pounds in nds in August 2009 and 122 er 2009. The record revealed nally refused to have his/her d no weights were assessed for try, February, May and July quarterly Minimum Data Set st 13, 2009, Section K3 - weight 14 was coded as "weight loss ". s note dated August 6, 2009 t sustained a significant oss of 11% in 6 months. The te was assessed as good at		<ul> <li>1a. A comprehensive nutrition with recommendation was resident #14 by the register on 10/26/09.</li> <li>1b. All nutritional recommendation resident #14 were implementation 10/26/09 and care planned.</li> <li>2. All residents with significat change were checked and the dietitian on 10/26/09 at in compliance.</li> <li>3. The Food Services Direct will check monthly resider ensure adequacy of nutrit nutritional documentation changes.</li> <li>4. Problems related to all signification of the dietitian on different to an ensure adequacy of nutrit nutritional documentation changes.</li> <li>4. Problems related to all signification of the dietitian of the diet</li></ul>	completed on ered Dietitian ations for nented on ed. Int weight d reviewed by nd found to be or and Dietician hts' weights to ion and proper for significant ervention will o the discussed in the d Quarterly QA	11/27/0

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	10/27/2009
FORM A	<b>APPROVED</b>
OND NO	0000 0004

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIP	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUI	LDING	; 	COMPLETED	
		095031	B. WIN	IG			
	<u>_</u>	033031				10/1	3/2009
NAME OF PR	OVIDER OR SUPPLIER						
ROCK CF	REEK MANOR NURSIN	IG CTR		}	131 O STREET NW ASHINGTON, DC 20037		
				44		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 514	Continued From page	ge 34	F	514			
		onsumed. The subsequent					
		note dated September 18, 2009			·		
		nt weight loss of 11% over 4 er 7 months. The resident ' s					
		from " good " the previous					
	month to " poor - fai	ir " with a meal consumption of					)
	25-50%. Nutritional	recommendations included "					ļ
Į		ighed monthly and encourage to		·			
	eat = 75% of meals.						ļ
	A face-to-face interv	iew was conducted with					
	Employee #24 on O						
		AM. In response to a query		[			
		ons associated with residents		1			
		ant, unplanned weight loss with		- {			
		nsumption, he/she stated that ons are individualized and may		- }			
		limited to weekly weight					
	assessments, calorie						
	supplements and die	etary preferences. In response					
		interventions implemented for					
}		e stated that a bedtime snack		[			
		nd food preferences were I in addition to close monitoring		ł			
		nption. He/she acknowledged			•		
		nutrition assessments lacked					
		ementioned interventions. The					
Ì	record was reviewed	October 8, 2009.					
ļ	h) A review of Posic	dent #14's plan of care revealed					
		team identified "Therapeutic					
}		etes Mellitus " as a problem,					
		ed interventions and goals.					
1							
		rementioned monthly weight 4 sustained a significant					
	record, Resident #12	r sustaineu a signiitudilt					
)							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		E & MEDICAID SERVICES	(XZ) MULTI	PLE CONSTRUCTION	OIVIB N (X3) DATE S	0. 0938-03
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN		COMPLE		
		095031	B. WING		10/	13/2009
	OVIDER OR SUPPLIER	SING CTR	2	REET ADDRESS, CITY, STATE, 2 2131 O STREET NW WASHINGTON, DC 2003	UP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	' STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE AC	N OF CORRECTION TION SHOULD BE CROSS- PPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 514	Continued From	bage 35	F 514			
	-weight-loss-betwe 2009.	een-the-period-of-June-and-August				
	included an entry this quarter, eats subsequent care 2009 revealed an	was revised on August 6, 2009 and : " no significant weight changes good, weight 125 pounds " A plan revision dated September 18, entry, " no significant weight or to fair, weight 122 pounds."				
	and September 1	care plan revisions of August 6th 8, 2009 were inaccurate and a nutrition assessments of August 009.				
	Employee #24 du October 13, 2009	review and confirmed by ring a face-to-face interview on at approximately 11:00 AM. The ved October 8, 2009.				
}						
			(			
}						
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