| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095031 | A. BUILDING _____ B. WING _____ | 10/13/2009 |

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| ROCK CREEK MANOR NURSING CTR | 2131 O STREET NW WASHINGTON, DC 20037 |

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| F 000 | INITIAL COMMENTS | F 000 | 1a Spanish speaking staff members were identified and the resident #18's responsible party has given a telephone consent to use them as interpreters. A written consent form has been mailed to the responsible party for a written affirmation.<br>1b. On call Spanish speaking interpreter program for non administrative hours and weekends was initiated on 10/26/09 **(See attachment 1A,1B & 1C).**<br>1c. The facility already has enough Spanish speaking staff to help during administrative hours.<br>1d. Policy on non-English speaking residents was revised on 11/2/09 **(See attachment II).**<br>1e. Facility's communication book for non-English speaking residents with frequently used Spanish words was updated to include more words.<br><br>2. Care Plans of all Spanish speaking residents were reviewed on 10/30/09 for inclusion of on-call Spanish speaking interpreter.<br><br>3a. Staff were in-serviced on Non-English Speaking Program relative to interpreter and contact numbers on 11/2/09 at all staff meeting.<br>3b. Nurses will document each time the services of the on-call translator is used.<br>3c. IDT members will review the residents' plan of care for appropriate intervention during the care conference. | |
| | The recertification survey was conducted on October 6 through 13, 2009. The following deficiencies were based on observations, record review and staff and resident interviews. The sample included 26 residents based on a census of 173 residents on the first day of survey and 26 supplemental residents. The following complaints were investigated:<br>09-042 [DC00001705], 09-043 [DC00001712], 09-061 [DC00001748]. | | | |
| F 241 SS=D | 483.15(a) DIGNITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review, resident, staff and family interviews for two (2) of 26 sampled residents, it was determined that facility staff failed to promote care in a manner and in an environment that maintains or enhances the resident ' s dignity and in full recognition of the resident's individuality. Residents #18 and 23.<br><br>The findings include:<br><br>1. Facility staff failed to ensure appropriate provision for communicating with the resident in his/her primary language-Spanish and to honor the resident's wishes not to use adult briefs for Resident #18.<br><br>According to a quarterly MDS completed on September 21, 2009 the resident is 99 years old. | F 241 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/17/09

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

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| F 241 | Continued From page 1<br>Section B-Cognitive Patterns was coded as long-term memory is "Ok"; short-term memory "problem". He/She was coded zero (0) [Meaning behavior was not present] in Section E-Mood and Behavior Patterns. He/She required limited assistance with bed mobility, transfer, and walk in room and corridor in Section G-Physical Functioning and Structural Problems. Section H the resident was coded as continent of bowel and bladder.<br><br>The nursing notes revealed the following:<br><br>"September 25, 2009, Third quarter IDT [Interdisciplinary Team] held for resident ....Staff member to use communication book when interacting with resident, diapers for resident at about 7:00 PM each day ..."<br><br>"September 26, 2009 at 10: 00 PM, ...Staff encouraged resident to wear [adult briefs] at night ... " Staff unable to understand resident's language (Spanish) ... "<br><br>"September 27, 2009 at 2:00 AM, Many attempts ...made to encourage resident with the use of [adult brief] at night but continue to speak Spanish when staff could not understand ... "<br><br>"September 28, 2009 at 2:00 AM ...Staff encouraged him/her to wear [adult briefs] ... "<br><br>A face-to-face interview was conducted with Employee #7 on October 6, 2009 at approximately 11:00 AM. He/she said, "After the resident has had several falls, we appealed to the resident to use pull-ups/adult briefs at night to reduce the incidents of fall at night. The resident refused. During the last IDT meeting we | F 241 | 4. Problems related to communication barriers between residents and staff will be reported to the DON, the Administrator and discussed in the Risk Management/QA meeting and in the Quarterly QA meeting.<br><br>1a. Use of brief on the resident #18 was discontinued on 10/9/09.<br>1b. A toileting plan was initiated on 10/9/09.<br><br>2. Care of all continent residents with potential for fall was reviewed for appropriate treatment plan on 10/30/09.<br><br>3a. Nursing staff were re-in-serviced on the management of continent residents with potential for fall by 10/30/09.<br>3b. IDT members were retrained on care plan decisions that reflect LTC regulations and holistic approach for resident dignity and safety on 11/2/09.<br><br>4. Deficient practice and staff indecision related to issues of resident safety and dignity will be reported to the DON unto Administrator for remedial action and discussed in the monthly Risk Management /QA and Quarterly QA meeting. | 11/27/09<br><br>11/27/09 |

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| F 241 | Continued From page 2 | F 241 | | |

presented the use of adult briefs at night with the family, they agreed with the team. The family persuaded the resident to use adult briefs at night only. The resident has not had a fall incident since we instituted the use of adult briefs at night. "

A face-to-face interview was conducted with Employees #2 and 7 on October 9, 2009 at approximately 1:00 PM. Employee #2 stated, "That facility staff would institute an every 2-hour assistant/reminder to the bathroom and emphasize the importance and need for the night shift staff to update the communication book as needed to meet their needs and or contact the identified staff member that is available after off-hours. Employee #2 also added that the facility would explore other interventions that will assist in maintaining and or enhancing the resident's dignity and is acceptable to the resident."

A face-to-face interview was conducted on October 13, 2009 at 1:00 PM with the resident in the presence of the family member. The family member translated for this investigator. According to the family member, the resident protested the idea of using the pull-up, but was persuaded to use the brief only at night to reduce the potential for fracture related to fall. The family member stated because there is no Spanish speaking staff on the night shift, if and when the resident calls for help, the staff are frustrated because they do not understand the resident, and they are unable to communicate with the resident in his/her primary language and are therefore unable to provide the resident with appropriate needed services.

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| F 241 | Continued From page 3<br>Facility staff failed to ensure appropriate provision for communicating with the resident in his/her primary language-Spanish and honor the resident's wishes not to use adult briefs.<br>Additionally, a review of the resident's clinical record lacked evidence that facility staff explored other appropriate interventions to aid in the resident's bathroom use and continent care. The record was reviewed October 13, 2009.<br><br>2. Facility staff failed to return Resident #23's personal possessions including his/her dentures and eyeglasses that were removed from the resident's room during the time when the room was painted.<br><br>During the resident council group meeting with the State Agency on October 8, 2009 at approximately 1:30 PM and a face-to-face interview on October 9, 2009 at approximately 3:45 PM, Resident #23 verbalized the loss of his/her dentures and newly obtained eyeglasses.<br><br>Resident # 23 alleged that his/her eyeglasses and dentures were in the top drawer of his/her assigned nightstand. Resident # 23 alleged that the staff member left his/her room with his/her personal possessions. The entire contents from his/her nightstand without his/her permission, and or explanation of where the personal possessions will be kept or returned.<br><br>A face-to-face interview was conducted with Employee #17 on October 9, 2009 at approximately 2:55 PM. He/she stated that he/she is not aware of the resident's dentures but knows for a fact that the resident had newly prescribed eyeglasses. Employee #17 stated that he/she facilitated the application for the | F 241 | 1a Resident #23 received new eye glasses from America's Best Contacts, 1100 Connecticut Ave., NW, Washington, DC 20036 on 11/06/09.<br>1b. An inventory form for resident #23 was initiated to track residents' personal items when they are moved and returned to the resident's room during room sanitation process.<br><br>2. Other residents with eye glasses have been re-assessed and eyeglasses were found to be in good condition and properly cared for on 10/30/09.<br><br>3a. An updated personal property inventory will be kept for all residents; inventory sheet will be kept in resident chart.<br>3b. Nursing staff was in-serviced on 10/21/09 on the proper care of residents' eye glasses' including documentation.<br>3c. RCC will monitor for compliance.<br>3d. Social Service will ensure timely compliance in case of loss.<br><br>4 Problems related to eye glasses and other assistive devices will be reported to the DON, the Administrator and discussed in the Risk Management/QA meeting and in the Quarterly QA meeting. | 11/27/09 |

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| F 241 | Continued From page 4<br>eyeglasses. Additionally, Employee #7 revealed that the eyeglasses were dispensed to the resident on April 27, 2009 and the painting of the resident's room was completed on July 20, 2009.<br><br>A face-to-face interview was conducted on October 9, 2009 at 3:10 PM with Employee #23. He/she acknowledged that the resident had a pair of old dentures and newly prescribed eyeglasses. Employee #23 stated that he/she accompanied the resident on the trip for the fitting and pick-up of the eyeglasses.<br><br>Facility staff failed to return Resident #23's personal possessions including his/her dentures and eyeglasses that were moved during the painting of the resident's room.<br><br>A face-to-face interview was conducted with Employee #7 on October 9, 2009 at approximately 5:00 PM. He/she acknowledged that he/she had been informed of the validity of the resident's allegation and that the facility will have to replace the resident's missing property. The record was reviewed October 9, 2009. | F 241 | 1. Resident #23 was seen by facility's dentist on 11/13/09 and dental impressions taken.<br><br>2. Other residents with dentures have been re-assessed and dentures found in good condition on 10/30/09.<br><br>3a. An updated personal property inventory Including dentures will be kept for all residents.<br>3b. Nursing staff was in-serviced 10/21/09 on proper care of resident dentures, Including documentation on each shift.<br>3c. RCC will monitor for compliance.<br>3d. Social Services will ensure timely compliance in case of loss.<br><br>4. Problems related to dentures and other assistive devices will be reported to DON and the Administrator for remedial action and discussed in the Risk Management/QA meeting and in the Quarterly QA meeting. | 11/27/09 |
| F 250 SS=D | 483.15(g)(1) SOCIAL SERVICES<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interview and record review for one (1) of 26 sampled residents, the social worker failed to assess and/or document the | F 250 | 1a. Resident #11 was not harmed by deficient practice.<br>1b. The residents psychosocial assessment was completed on 10/29/09.<br><br>2. Social Workers will audit charts to ensure that all psychosocial assessments are completed and up to date. Completion date 11/18/09. | |

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| F 250 | Continued From page 5<br>psychosocial status for Resident #11 with a communication language barrier.<br><br>The findings include:<br><br>A review of the clinical record revealed that the social worker failed to assess and/or document the resident's psychosocial needs since admission date of July 20, 2009.<br><br>A review of the admission "social worker progress note" dated July 28, 2009 at 1:25 PM revealed, "...Social worker met with resident for initial assessment. Resident was admitted on July 20, 2009. This worker was out of facility on vacation at the time of admission. Met with resident. Resident was up in Geri-chair. Reviewed resident record. Resident has expressive aphasia. Resident looked at social worker but was unable to express and answer questions. Discussed resident in IDT for initial assessment. According to IDT members [family member] is very supportive. Will contact [family member] to assist with admission paperwork..."<br><br>A review of nurse's note revealed that resident's [family member] visited facility on the following dates:<br><br>7/21/2009, 7/22/2009, 7/23/2009, 7/25/2009, 7/26/2009, 7/31/2009, 8/2/2009, 8/4/2009, 8/7/2009, 8/16/2009, 8/28/2009, 9/14/2009 and 9/18/ 2009.<br><br>Although the [family member] was present in the facility on the aforementioned dates, the clinical record lacked evidence of the social worker's attempts to contact the family to further assess the residents' psychosocial status for the initial | F 250 | 3a. Social Workers were in-serviced by the social worker consultant on the time frame to complete psychosocial assessments on 10/30/09.<br>3b. Medical records staff will continue with a monthly audit to ensure completion of initial and quarterly psychosocial assessments.<br><br>4. Problems related to the accurate/timely completion of psychosocial assessments will be reported to the Administrator and addressed in the monthly Risk Management/QA and Quarterly QA meeting for remedial actions. | 11/27/09 |

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| F 250 | Continued From page 6<br>assessment and to complete paperwork.<br><br>A face-to-face interview was conducted with Employee #15 on October 7, 2009 at 2:00 PM. He/she acknowledges that resident's [family member] was called and message left but he/she has not been able to contact or speak with the [family member]. The record was reviewed October 8, 2009. | F 250 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on the environmental tour conducted on October 6 and 7, 2009 between 9:00 AM and 10:30 AM, it was determined that the facility failed to provide effective housekeeping and maintenance services as evidenced by: Privacy curtains that were loose in 19 of 50 resident rooms; damaged privacy curtains in four (4) of 50 resident rooms; dusty air vents and soiled walls in five (5) of five (5)shower rooms; damaged ceiling tiles in two (2) of five (5) resident shower rooms; and damaged blinds and soiled walls in the rehabilitation room. These observations were made in the presence of Employees #12 and 30.<br><br>The findings include:<br><br>1. Privacy curtain tracks were loose in 19 of 50 resident's rooms observed; rooms 102, 103, 108, 110, 114, 115, 117, 119, 120, 203, 204, 206, 210, 212, 213, 214, 218, 219, and 221. | F 253 | 1. Loose privacy curtain tracks will be secured and completed by outside contractor by 11/27/09 for residents in rooms 102,103,108,110,114,115,117, 119,120,203,204,206,210,212,213,214, 218,219 and 221**(See attachment III ).**<br><br>2. All privacy curtain tracks were checked on 10/19/09 and found to be in compliance.<br><br>3a. The Director of Environmental Service and the Maintenance Director will monitor all privacy curtain tracks during weekly grand rounds to ensure they are secured.<br><br>3b. Loose privacy curtain tracks will be checked and recorded by housekeeping technicians in the maintenance log for quick repairs by maintenance.<br><br>4. The Director of Environmental Service will report problems of loose privacy curtain tracks to the Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for remedial action. | 11/27/09 |

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| F 253 | Continued From page 7<br>2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed; rooms #114, 117, 301 and 319.<br><br>3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.<br><br>4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.<br><br>5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.<br><br>6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.<br><br>The findings were acknowledged by Employees #12 and 30. | F 253 | 1a. The damaged privacy curtains in rooms 114, 117, 301 and 319 will be replaced on 11/15/09.<br><br>1b. Contract bids are taken to get a proposal to replace all privacy curtains on the 1st and 3rd floors **(See attachment IV).**<br>1c. Room 319 is a private room and never had a privacy curtain.<br><br>2. Privacy curtains for other residents have been assessed and will be replaced or repaired as needed by 11/27/09..<br><br>3a. The Director of Environmental Service will monitor and check all privacy curtains to ensure they are clean and in good condition.<br>3b. Housekeeping technician will be trained to check for damaged privacy curtains to be reported to the Director of Environmental Services.<br><br>4. The Director of Environmental Service Will submit problems with torn privacy Curtains to the Administrator for remedial Action and will be discussed in the Risk Management/QA meeting and Quarterly QA meeting. | 11/27/09 |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | | |

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| F 253 | Continued From page 7<br>2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319.<br><br>3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.<br><br>4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.<br><br>5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.<br><br>6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.<br><br>The findings were acknowledged by Employees #12 and 30. | F 253 | 1. Soiled exhaust vents and walls located in the five shower rooms were cleaned on 10/13/09.<br>2. Soiled exhaust vents throughout the facility have been checked by the Director of Maintenance on 10/13/09 and found to be in compliance .<br><br>3. Exhaust vents will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance.<br><br>4. Deficient practice related to soiled exhaust vents will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management /QA and Quarterly QA meeting. | 11/27/09 |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | | |

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| F 253 | Continued From page 7<br>2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319.<br><br>3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.<br><br>4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.<br><br>5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.<br><br>6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.<br><br>The findings were acknowledged by Employees #12 and 30. | F 253 | 1. First and third floor damaged ceiling tiles located in the shower rooms were repaired on 10/13/09.<br><br>2. Ceilings tiles through out the facility have been checked by the Director of Maintenance and found to be in compliance on 10/13/09.<br><br>3. Ceiling titles will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance.<br><br>4. Deficient practice related to damaged Ceilings will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management /QA and Quarterly QA meeting. | 11/27/09 |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | | |

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| F 253 | Continued From page 7<br>2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319.<br><br>3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.<br><br>4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.<br><br>5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.<br><br>6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.<br><br>The findings were acknowledged by Employees #12 and 30. | F 253 | 1. The 3 damaged window blinds located in the rehabilitation room were replaced on 10/13/09.<br><br>2. Window blinds throughout the facility have been checked by the Director of Maintenance and found to be in compliance on 10/13/09.<br><br>3. Window blinds will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance.<br><br>4. Deficient practice related to Window blinds will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management /QA and Quarterly QA meeting. | 11/27/09 |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | | |

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| F 253 | Continued From page 7<br>2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319.<br><br>3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed.<br><br>4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed.<br><br>5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area.<br><br>6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed.<br><br>The findings were acknowledged by Employees #12 and 30. | F 253 | 1. Soiled walls in the rehabilitation area were cleaned on 10/19/09.<br><br>2. All walls were checked on 11/3/09 throughout the facility and found to be in compliance.<br><br>3 The Director of Environmental Services will check all walls during daily rounds for cleanliness and to ensure immediate clean-up by housekeeping technicians.<br><br>4. The Director of Environmental Services will report problems with soiled walls to the Administrator for remedial action and will be discussed in the Risk Management/QA meeting and Quarterly QA meeting. | 11/27/09 |
| F 278 SS=D | 483.20(g) - (j) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and | F 278 | MDS assessments for:<br><br>1a. Resident #3 was corrected to reflect pressure ulcer stage 3 wound on 10/29/09.<br>1b. Resident #4 was corrected on 10/29/09 to reflect resident long acting intramascular injection.<br>1c. Resident #6 was corrected on 10/07/09, for a fracture that never occurred.<br>1d. Resident #15 initial assessment R2 section signed 10/29/09.<br>1e. Resident #22 was corrected on 10/29/09 to reflect resident correct coding for enteral feeding | |

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| F 278 | Continued From page 8<br>false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for five(5) of 26 sampled residents, it was determined that facility staff failed to accurately code Minimum Data Sets (MDS) for one (1) resident for pressure ulcers, one (1) resident for medications, one (1) resident for falls, one (1) resident for enteral intake and range of motion and the RN Coordinator failed to sign in section R2b that the assessment was complete for one (1) resident.<br>Residents #3, 4, 6, 15 and 22.<br><br>The findings include:<br><br>1. Facility staff failed to accurately code Resident #3 for pressure ulcers.<br><br>A review of Resident #3' s quarterly MDS dated July 23, 2009 revealed that facility staff failed to accurately code the stage of the resident's pressure ulcer in Section M1. The resident' s ulcer was coded as Stage two on the MDS.<br><br>A review of the "Decubitus Report" dated July 20, 2009 (on which the Wound Nurse documents the | F 278 | 2. Other MDS assessments were reviewed on 11/3/09 for miscoding related to fracture, long acting intramuscular injections, staging of pressure ulcers, required RN signatures, enteral feeding and found to be in compliance<br><br>3a. Inter-disciplinary team members were re-in-serviced on 11/2/09 by the MDS coordinator on how to accurately code on the MDS.<br>3b. The MDS coordinator will review coding compliance daily using the MDS/Care plan audit tool.<br><br>4. Problems related to MDS coding will be reported to the Administrator for remedial action and discussed in the monthly Risk Management and Quarterly QA meeting. | 11/27/09 |

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| F 278 | Continued From page 9 | F 278 | | |

stage of each wound) revealed that the pressure ulcer was documented as a Stage Three.

A face-to-face interview was conducted with Employee #7 at approximately 11:00 AM on October 13, 2009. He/she acknowledged that the pressure ulcer was incorrectly coded on the MDS. The record was reviewed on October 7, 2009.

2. Facility staff failed to accurately code Section O1 [Number of Medications] on the "Significant Change in Status Assessment" MDS completed on July 17, 2009 for Resident # 4.

A review of Resident # 4's clinical record revealed an "Interim Order Form" dated and signed March 18, 2009 and renewed on June 22, 2009 that directs "Psych [Psychiatrist] order Haldol Dec. [Haldol Decanoate] 50 mg IM [Intramuscular] q [Every] 3weeks [for] Hallucination..."

A further review of the resident's clinical record revealed the resident's Medication Administration Record [MAR] that indicated that the resident was administered Haldol on July 4, 2009 as evidenced by the initial across from the entry for Haldol.

A review of the "Significant Change in Status Assessment " MDS completed on July 17, 2009 revealed that Section O1 was coded as "zero" for number of different medications used .

A face-to-face interview was conducted with Employees # 6 and 13 on October 17, 2009 at approximately 11:00 AM. They acknowledged that the coding was inaccurate. The medication was administered outside the look back window and did not take into consideration that the Haldol Decanoate was a long acting antipsychotic

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| F 278 | Continued From page 10<br>~~medication. The record was reviewed October 7,~~ 2009.<br><br>3. Facility staff failed to accurately code the quarterly Minimum Data Set for "Accidents" for Resident #6.<br><br>A review of the quarterly Minimum Data Set (MDS) signed July 9, 2009 revealed Section J4 [Accidents], was coded as "other fracture in the last 180 days."<br><br>A review of the clinical record for the period of December 2008 through July 2009 lacked evidence that Resident #6 sustained a fracture.<br><br>A face-to-face interview was conducted with Employee #9 on October 6, 2009 at approximately 10:30 AM. He/she stated that the MDS was coded inaccurately because the resident had not sustained a fracture in the last 180 days from the July 2009 MDS.<br><br>A face-to-face interview was conducted with Employee #13 on October 7, 2009 at approximately 3:50 PM. He/she acknowledged the MDS was coded inaccurately. The record was reviewed October 7, 2009.<br><br>4. Facility staff failed to sign Section R2 on the admission MDS for Resident #15.<br><br>The admission MDS completed March 2, 2009 revealed that Section R2, "Signature of Person Coordinating the Assessment" was blank.<br><br>According to the MDS 2.0 User's Manual, page 3-212, "Federal regulations require the RN assessment coordinator to sign and thereby | F 278 | | |

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| F 278 | Continued From page 11<br>certify that the assessment is completed."<br><br>A face-to-face interview was conducted with Employee # 9 on October 9, 2009 at 3:30 PM. He/she acknowledged that Section R2 was not signed by the RN Coordinator. The record was review October 9, 2009.<br><br>5. A review of the clinical record for Resident #22 revealed facility staff failed to accurately code the significant change MDS for parenteral/enteral intake. Additionally, the annual and significant change MDS ' were inaccurately coded for functional range of motion.<br><br>According to the history and physical examination signed February 8, 2009, Resident #22's diagnoses included aphasia, dysphagia, dementia, renal failure, contractures, anoxic encephalopathy, hypertension, osteoarthritis and deep vein thrombosis.<br><br>a.) A review of the Significant Change MDS signed July 3, 2009 revealed Section K, Oral/Nutritional status was coded as 51-75% of total daily calories received via tube feedings.<br><br>Enteral orders dated July 1, 2009 directed " Jevity 1.2 calories via gastrostomy tube @ 55 milliliters per hour for 18 hours via pump." According to the Medication Administration Record for July 2009, the enteral feeding was administered during the time period of 4:00 PM - 10:00 AM daily.<br><br>A face-to-face interview was conducted with Employee #16 on October 9, 2009 at approximately 11:00 AM. In response to a query regarding Resident #22 ' s nutritional status, | F 278 | | |

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| F 278 | Continued From page 12 | F 278 | | |

he/she stated the resident receives nothing by mouth and enteral feedings are administered via pump 18 hours daily to meet his/her hydration and nutritional needs.

Employee #16 acknowledged that the MDS was coded inaccurately and that 100% of the resident's daily caloric intake was received enterally.

b.) According to the MDS 2.0 User's Manual, page 3-109/110, Functional Limitation in Range of Motion, Code "0" for no limitation, resident has full function range of motion and/or voluntary movement. Code "1" for limitation on one side of the body and/or partial loss of voluntary movement. Code "2" for limitations on both sides of the body and/or full loss of voluntary movement.

A review of the Significant Change MDS signed July 3, 2009 and the Annual MDS signed April 4, 2009 revealed Section G4, Functional Limitation in Range of Motion was coded as "00 - no limitations."

A review of the rehabilitation assessment dated June 30, 2009 revealed Resident #22 was totally dependent for mobility and self care and unable to move independently.

A face-to-face interview was conducted with Employee #16 on October 9, 2009 at approximately 11:00 AM. In response to a query regarding Resident #22's functional ability, he/she stated that the resident was admitted January 2009 and was totally dependent at the time of admission. He/she lacks the ability to move independently. Hand and wrist splints are applied

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| F 278 | Continued From page 13<br>daily to manage upper extremity contractures. He/she acknowledged the MDS lacked evidence of the resident's loss of voluntary movement. The record was reviewed October 9, 2009. | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview of two (2) of 26 sampled residents, it was determined that facility staff failed to review and revise care plans after quarterly Minimum Data Set (MDS) assessments. Residents #4 and 13.<br><br>The findings include: | F 280 | 1. Care plans for residents #4and #13 were up-dated to reflect current health status on 10/16/09.<br><br>2. All care plans were reviewed on 11/3/09 for updated notes and found to be in compliance.<br><br>3a. The interdisciplinary team members were retrained on 10/23/09 on the importance of completing and updating MDS/care plans after each care conference meeting.<br>3b. Medical records staff will audit care plans monthly to ensure that they are updated.<br><br>4. Problems of not updating care plans will be reported to the DON, AA/QA for remedial action and discussed in the Monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 280 | Continued From page 14 | F 280 | | |

Facility staff failed to review and revise multiple care plans after periodic assessments for Residents #4 and 13.

1. A review of Resident # 4 ' s clinical record revealed that he/she had a periodic quarterly assessment completed on March 16, 2009 as evidenced by a signed and dated Minimum data Sets (MDS) .

A further review of Resident # 4's clinical record revealed a "Care Plan Problem List " that listed twenty-one active problems. Nineteen of the listed problems were active and initiated on or before September 2008 and were all updated/evaluated on December 22, 2008 and June 17, 2009. Problem #6 "Weight maintenance Care Plan"; and Problem #15 "Abnormal Labs Care Plan " were updated/evaluated after the resident was assessed and a quarterly MDS completed on March 16, 2009.

Facility staff failed to review and revise the resident's following multiple care plans after the resident was assessed and a quarterly MDS was completed on March 16, 2009: " Physical mobility, dental, fall prevention, hypertension, risk for constipation, psychoactive drug use, agitation, depression, self care deficit, pain, delusion, non compliance, allergy, territorial behavior, vision, cognitive loss/dementia, dehydration and behavior-hoard. "

A face-to-face interview was conducted with Employee #6 on October 17, 2009 at approximately 11:00 AM. After reviewing the resident's clinical record, he/she acknowledged the above findings. He/she added, "It was an

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| F 280 | Continued From page 15<br>~~oversight." The record was reviewed October 7,~~ 2009.<br><br>2. A review of Resident # 13's clinical record revealed that the resident was accessed on March 19, June 18, and September 14, 2009 as evidenced by the signed and dated respectively quarterly, annual and quarterly MDS.<br><br>A further review of the resident ' s clinical record revealed that the following multiple care plans were not updated and revised /evaluated after the resident was assessed and a quarterly MDS completed on March 19, 2009. "Cognitive loss/dementia, psychoactive drug use, self care deficit, vision, incontinence, fall prevention, dental, 9+ medication, diabetes, allergy, dehydration risk, aspiration risk, anticoagulation, seizure disorder, risk for pressure ulcer. "<br><br>Facility staff failed to review and revise Resident #13's multiple active care plans after the resident was assessed and a quarterly MDS completed on March 19, 2009.<br><br>A face-to-face interview was conducted with Employee # 6 on October 17, 2009 at approximately 3:40 PM. After reviewing the resident's clinical record, he/she acknowledged the above findings. He/she added, "It was an oversight." The record was reviewed October 7, 2009. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced | F 281 | 1a. Resident #K1 was not harmed by the deficient practice.<br>1b. The resident's apical pulse was checked on 10/9/09 and found to be within normal range. | |

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| F 281 | Continued From page 16<br>by:<br>Based on observations during the medication pass conducted on October 8, 2009 between 8:00 AM and 8:30 AM, it was determined licensed staff failed to assess a residents' apical pulse prior to the administration of an antiarrhythmic medication in one (1) of 42 medication pass opportunities. Resident K1.<br><br>The findings include:<br><br>An observation during the medication pass conducted on October 8, 2009 between 8:00 AM and 8:30 AM on the 2nd floor nursing unit revealed that the nurse administered an antiarrhythmic medication without assessing Resident K1's apical pulse.<br><br>A review of Resident K1's clinical record revealed physician's orders dated August 17, 2009 that directed "Digoxin 0.125mg, one (1) tablet by mouth daily for congestive heart failure."<br><br>A review of the Medication Administration Record for October 2009 revealed Digoxin was scheduled for administration at 8:00 AM daily.<br><br>During the medication pass observation, the nurse was observed preparing Resident K1's medications, one of which included Digoxin 0.125 mg. He/she offered the resident a cup of water and the medications. The resident swallowed the pills and the nurse verified that the resident swallowed the medications. As the resident departed, the nurse was queried regarding the resident ' s vital signs. He/she stated that vital signs were not obtained.<br><br>The nurse immediately asked the resident to | F 281 | 1c. The licensed staff was re-trained on 10/24/09 on the importance of checking apical pulse before the administration of Digoxin.<br><br>2. The MARs of all residents receiving Digoxin were reviewed on 10/30/09 for apical pulse documentation and found to be in compliance.<br><br>3a. Licensed staff were re-in-serviced on 10/30/09 on the importance of vital sign assessment before the administration of an antiarrhythmic medication.<br>3b. Random medication pass audit will be conducted with the charge nurses on a quarterly basis and PRN to ensure accuracy of medication administration.<br><br>4. Problems related to the resident's Medication administration will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| ROCK CREEK MANOR NURSING CTR | 2131 O STREET NW WASHINGTON, DC 20037 |

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| F 281 | Continued From page 17<br>return to his/her room so that vitals could be assessed. The nurse was observed auscultating the resident ' s apical pulse. The result was 82 beats per minute.<br><br>According to the guidelines of Lexi-Comp ' s Drug Reference Handbook - Geriatric Dosage Handbook, 12th Edition, nursing implications for the administration of Digoxin include, " check apical pulse before giving. "<br><br>The findings were review and confirmed by Employee #6 during a face-to-face interview on October 8, 2009 at approximately 8:30 AM.<br><br>This deficiency has been cross referenced to CFR 483.25. | F 281 | | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, staff interview and record review for one (1) of 26 sampled residents, and one (1) of 26 supplemental residents, it was determined that rehabilitation services failed to follow-up on a physician's order for therapy for one (1) resident and licensed staff failed to assess a residents' apical pulse prior to the administration of an antiarrhythmic medication in one (1) of 42 medication pass opportunities. | F 309 | 1a. The facility clarified that resident #11 was not on hospice care.<br>1b. The resident was re-screened on 10/12/09 and admitted for PT, OT and ST.<br><br>2. All other resident physician orders were reviewed on 11/5/09 for rehabilitation services and found to be in compliance.<br><br>3a. A weekly chart audit will be conducted by the RCC to ensure that orders for rehabilitation services are done per physician's orders.<br>3b. Licensed staff will be in-serviced on 11/6/09 on the importance of reviewing physician orders to ensure that orders for rehabilitation services are followed-up in a timely manner. | |

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| F 309 | Continued From page 18<br>Residents #11 and K1.<br><br>The findings include:<br><br>1. Facility staff failed to follow-up on a physician's order for rehabilitation services for Resident #11.<br><br>A review of Resident record revealed an order on the " Admission Order Sheet and Physician Plan of Care" dated July 7, 2009 that read, " Screen: Physical Therapy and Occupational Therapy " .<br><br>A review of the " Interdisciplinary Resident Rehab Screen Sheet" revealed a note dated July 21, 2009 that read, Patient is currently on hospice Patient not a rehab candidate. "<br><br>A review of admission note dated July 20, 2009 at 8:00 PM reads. "Resident is admitted for palliative care. According to hospital papers the family has opted for hospice care however [attending physician] holds a different view. Resident care coordinator to follow up with [attending physician]. "<br><br>A review of resident record revealed no record of resident being admitted to hospice care at facility.<br><br>A face-to-face interview was conducted with Employee #30 on October 8, 2009 at 2:15 PM. He/she stated that resident was screen on admission but because he/she was hospice he/she was not a rehab candidate. The record was reviewed October 8, 2009.<br><br>2. Facility staff failed to obtain an apical pulse prior to administering Digoxin for Resident K1.<br><br>An observation during the medication pass | F 309 | 4. Deficient practice related to rehab services and physician orders will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 309 | Continued From page 19<br>conducted on October 8, 2009 between 8:00 AM and 8:30 AM on the 2nd floor nursing unit revealed that the nurse administered an antiarrhythmic medication without assessing Resident K1's apical pulse.<br><br>A review of Resident K1's clinical record revealed physician's orders dated August 17, 2009 that directed " Digoxin 0.125mg, one (1) tablet by mouth daily for congestive heart failure. "<br><br>A review of the Medication Administration Record for October 2009 revealed Digoxin was scheduled for administration at 8:00 AM daily.<br><br>During the medication pass observation, the nurse was observed preparing resident K1's medications, one of which included Digoxin 0.125 mg. He/she offered the resident a cup of water and the medications. The resident swallowed the pills and the nurse verified that the resident swallowed the medications. As the resident departed, the nurse was queried regarding the resident's vital signs. He/she stated that vital signs were not obtained.<br><br>The nurse immediately asked the resident to return to his/her room so that vitals could be assessed. The nurse was observed auscultating the resident ' s apical pulse. The result was 82 beats per minute.<br><br>This deficiency has been cross referenced to CFR 483.20. | F 309 | 1a. Resident K1 was not harmed by the deficient practice.<br>1b. The resident's apical pulse was checked on 10/9/09 and found to be within normal range.<br>1c. The licensed staff was retrained on 10/24/09 on the importance of checking apical pulse before the administration of Digoxin.<br><br>2. The MARs of all residents receiving Digoxin were reviewed for apical pulse documentation and found to be in compliance by 10/30/09.<br><br>3a. Licensed staff were re-in-serviced on 10/30/09 on appropriate vital sign monitoring during medication administration (Digoxin).<br><br>3b. Random medication pass audit will be conducted with the charge nurses on a quarterly basis and PRN to ensure accuracy in medication administration.<br><br>4. Problems related to medication administration will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |
| F 311 SS=D | 483.25(a)(2) ACTIVITIES OF DAILY LIVING<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. | F 311 | | |

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| F 311 | Continued From page 20<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to provide appropriate treatment and services to maintain or improve his or her abilities for Resident #5.<br><br>The findings include:<br><br>Facility staff failed to give appropriate treatment and service to maintain and or improve Resident #5's Range of Motion to his/her neck.<br><br>A review of the Minimum Data Sets revealed the following: The quarterly MDS completed March 27, 2009 Section G4 [Test for Balance] Neck, Arm and hand was coded as no limitation or voluntary movement; The quarterly MDS completed June 22, 2009 and the annual MDS completed September 14, 2009 Section G4 Neck was coded as Limitation on one side and partial loss.<br><br>The record lacked documented evidence that rehabilitative and/or restorative services were provided to Resident #5 after the functional limitation in range of motion was assessed/identified.<br><br>A face-to-face interview was conducted on October 13, 2009 at 9:15 AM with Employee #6. He/she acknowledged that Resident #5 did not receive any rehabilitative and/or restorative services after the noted decline in the functional limitation in range of motion to the neck. The record was reviewed on October 13, 2009. | F 311 | 1a. Resident #5 was referred to rehab services for screening and evaluation for a decreased ROM on 10/14/09.<br><br>1b. Resident #5 was admitted for rehabilitation therapy on 10/15/09.<br><br>2. Quarterly MDS assessments were reviewed for decline in range of motion on 11/5/09 and found to be in compliance.<br><br>3a. The RCC will audit of the residents' ADL flow sheets and MDS quarterly to ensure that any significant decrease in a residents' ADLs is referred to rehabilitation for screening.<br>3b. A weekly audit of the resident's chart will be conducted by the RCCs to ensure that all physician orders are followed.<br>3c. Residents will be screened by the rehabilitation department quarterly during their assessment period.<br><br>4. Problems related to rehabilitation services and physician orders will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during a tour of the rehabilitation area, it was determined that the facility failed to ensure that the residents environment was free from accident hazards as evidenced by a fire extinguisher was stored unsecure in the resident area and a computer monitor was stored on the heater in the hallway. These observations were made in the presence of Employee #30.<br><br>The findings include:<br><br>1. A fire extinguisher was stored unsecured on a table in the treatment area in one (1) of one (1) fire extinguisher observed in the rehabilitation area.<br><br>2. A computer monitor was stored directly on the heater in the hallway located across from the elevators on the 6th floor.<br><br>These findings were acknowledged by Employee #30 at the time of the observation. | F 323 | 1. The Fire extinguisher located in the rehabilitation service office was re-mounted on the wall on 10/8/09.<br><br>2. Fire extinguishers throughout the facility have been checked on 10/8/09 by the Director of Maintenance and found to be in compliance.<br><br>2. Fire extinguishers will be checked weekly during Grand Rounds by the Director of Maintenance for continued compliance.<br><br>4. Deficient practices relating to fire extinguishers will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |
| F 334 SS=E | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION<br><br>The facility must develop policies and procedures | F 334 | | |

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| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during a tour of the rehabilitation area, it was determined that the facility failed to ensure that the residents environment was free from accident hazards as evidenced by a fire extinguisher was stored unsecure in the resident area and a computer monitor was stored on the heater in the hallway. These observations were made in the presence of Employee #30.<br><br>The findings include:<br><br>1. A fire extinguisher was stored unsecured on a table in the treatment area in one (1) of one (1) fire extinguisher observed in the rehabilitation area.<br><br>2. A computer monitor was stored directly on the heater in the hallway located across from the elevators on the 6th floor.<br><br>These findings were acknowledged by Employee #30 at the time of the observation. | F 323 | 1. The Computer monitor that was found on the 6th floor rehabilitation area was removed on 10/9/09 for appropriate storage.<br><br>2. No other unused computer monitor is present in the rehabilitation services area.<br><br>3a. Director of Rehabilitation services in-serviced staff on proper disposal of hazardous items on 10/29/09.<br>3b. Director of Rehabilitation services will conduct weekly rounds for continued compliance.<br><br>4. Deficient practices related to the disposal of old computers will be reported to the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |
| F 334 SS=E | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION<br><br>The facility must develop policies and procedures | F 334 | | |

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| F 334 | Continued From page 22<br>that ensures that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that –<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse | F 334 | 1a. Residents #2,3,7,8,11,12,15,20,F2,F3. F4,F5,F6,F7,F8,F9,F10,F11,F12,F13, F14,F16,F17,F18,F19,F20,F21,F22, and F23 have been offered PPD/FLU/ Pneumococcal vaccines and medical record documentation reflect their wishes.<br><br>1b. The facility's immunization policy was revised on 10/14/09 to emphasize residents'/responsible party's education, acceptance or refusal of immunization **(See attachment V ).**<br><br>2. A chart audit for other residents was conducted on 10/14/09 and found that the immunization acceptance and refusals by residents/responsible parties were documented by RCC and charge nurses.<br><br>3a. An in-service was offered to all nurses and RN supervisors on 10/26/09 to inform them about consent forms and the immunization policy and procedures.<br>3b. ADON who is an infection control nurse will monitor for compliance.<br>3c. Monthly chart audit will be conducted by medical records staff to ensure that immunizations have been offered, accepted or declined through a written consent.<br><br>4. Problems related to residents' immunization and PPD skin test will be reported to the DON, the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 334 | Continued From page 23 | F 334 | | |

immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:

Based on record review, staff interview for eight (8) of 26 sampled residents and 22 supplemental residents, it was determined that the facility staff failed to ensure that the resident's medical record included documentation that residents did not receive the influenza immunization due to the residents refusal/denial. Residents #2, 3, 7, 8, 11, 12, 15, 20, F2, F3, F4, F5, F6, F7, F8, F9, F10, F11, F12, F13, F14, F15, F16, F17, F18, F19, F20, F21, F22, and F23.

The findings include:

On October 9, 2009 at 11:09 AM, a review of the

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| F 334 | Continued From page 24<br>" Vaccine, PPD [Purified Protein Derivative], Chest X-Ray Audits " [line listing identifying all residents in the facility that received and/or refused the influenza immunization] was conducted and revealed that there was no documented information regarding the administration of Influenza immunizations for the following Residents: #2, 3, 7, 8, 11, 12, 15, 20 F2, F3, F4, F5, F6, F7, F8, F9, F10, F11, F12, F13, F14, F15, F16, F17, F18, F19, F20, F21, F22, and F23.<br><br>On October 9, 2009 at approximately 11:15 AM a face-to-face interview was conducted with Employee #4. He/she stated, "The resident's refusal or denial to have the Influenza vaccine should have been documented on the " Resident Consent Forms for Influenza and Pneumococcal Vaccines and Tetanus -Diphtheria Toxoids " form located in the resident ' s clinical record. Employee #4 further reviewed the " Vaccine, PPD [Purified Protein Derivative], Chest X-Ray Audits " line listing of residents and acknowledged that the medical records did not consistently contain documentation that the influenza vaccines had been refused/denied by residents. " | F 334 | | |
| F 371 SS=E | 483.35(i) SANITARY CONDITIONS<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | |

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| F 371 | Continued From page 25<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on October 6 through 9, 2009 during the tour of dietary services, it was determined that the facility failed to prepare and distribute food under sanitary conditions as evidenced by a soiled outdoor grill stored in the main dining room; a soiled floor in the main kitchen; water leaking from the ceiling in the main kitchen; and hot food temperatures were less than 140 degrees Fahrenheit. These observations were made in the presence of Employee #10.<br><br>The findings include:<br><br>1. The outdoor grill stored in the main dining room and was observed to be soiled with food residue in one (1) of one (1) outdoor grill observed.<br><br>2. The kitchen floor was soiled and in need of cleaning in one (1) of one (1) observation.<br><br>3. Water was leaking from the ceiling in the dishwashing area in one (1) of one (1) observation.<br><br>4. A test tray was conducted on October 9, 2009 at approximately 1:00 PM. The hot food temperatures were less than the required 140 degrees on the following items:<br><br>Fried Catfish was 124 degrees F (Fahrenheit)<br>Lima beans were 130 degrees F<br>Green beans were 132 degrees F<br><br>These findings were acknowledged by Employee #10 at the time observation. | F 371 | 1. The outdoor grill was cleaned on 10/6/09.<br><br>2. All dietary related equipment were checked on 10/14/09 for cleanliness and were found to be in compliance.<br><br>3a. In-service on how to properly clean the outdoor grill was given to dietary and therapeutic recreation staff on 10/14/09.<br>3b. The Director of Food Services and Director of Therapeutic Recreation will conduct daily a overall cleanliness of the outside grill for compliance.<br><br>4. Problems relating to cleaning the outside grill will be reported immediately to the Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for further remedial action.<br><br>1. The soiled floor in the kitchen was cleaned on 10/6/09.<br><br>2. Floor surfaces throughout the kitchen were checked for cleanliness and was found to be in compliance on 10/14/09.<br><br>3a. Dietary staff were re-in-serviced on 10/19/09 on how to clean the kitchen floor.<br>3b. The food service Director will conduct daily and weekly cleaning of the floor to ensure compliance.<br>3c. The facility will obtain proposals to assess the kitchen floor a part of a long-term renovation plan.<br><br>4. All problems relating to kitchen floor cleaning will be discussed in the monthly Risk Management/QA and Quarterly QA meetings for further remedial action. | 11/27/09<br><br>11/27/09 |

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| F 371 | Continued From page 25<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on October 6 through 9, 2009 during the tour of dietary services, it was determined that the facility failed to prepare and distribute food under sanitary conditions as evidenced by a soiled outdoor grill stored in the main dining room; a soiled floor in the main kitchen; water leaking from the ceiling in the main kitchen; and hot food temperatures were less than 140 degrees Fahrenheit. These observations were made in the presence of Employee #10.<br><br>The findings include:<br><br>1. The outdoor grill stored in the main dining room and was observed to be soiled with food residue in one (1) of one (1) outdoor grill observed.<br><br>2. The kitchen floor was soiled and in need of cleaning in one (1) of one (1) observation.<br><br>3. Water was leaking from the ceiling in the dishwashing area in one (1) of one (1) observation.<br><br>4. A test tray was conducted on October 9, 2009 at approximately 1:00 PM. The hot food temperatures were less than the required 140 degrees on the following items:<br><br>Fried Catfish was 124 degrees F (Fahrenheit)<br>Lima beans were 130 degrees F<br>Green beans were 132 degrees F<br><br>These findings were acknowledged by Employee #10 at the time observation. | F 371 | 1. Water leak in the kitchen from the ceiling at dish machine area was resolved on 10/8/09.<br><br>2. The facility was checked for leaks by the Director of Maintenance and found to be in compliance on 10/8/09.<br><br>3. Water leaks from the ceiling in the kitchen area will be checked daily during AM kitchen Rounds by the Director of Maintenance and Food Service Director for continued compliance.<br><br>4. Deficient practices relating to ceiling leaks will be reported immediately to the director of Maintenance unto the Administrator for remedial action and discussed in the Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 371 | Continued From page 25 | F 371 | 1a. Resident was not harmed by the deficient practice.<br>1b. Food for the affected residents were reheated.<br><br>2 . Residents' food temperature was checked on the unit on 10/14/09 and found to be in compliance with temperature range of equal or greater than140°F for hot food.<br><br>3a. Food temperature will be monitored weekly to assure correct temperature when they arrive on the unit.<br>3b. Both nursing and Dietary staff were in-serviced on 10/21/09 on the correct serving food temperatures on unit and the reheating of foods as needed.<br>3c. Elevator #3 will be on reserve at meal times to ensure a quick meal delivery to the units.<br>3d. Testing for adequate food temperatures will be conducted daily by the Food Service Director on the test tray on the unit.<br><br>4. Problems relating to temperature of food arriving on unit will be reported immediately to ADON, and discussed in monthly Risk Management and Quarterly QA meetings for further remedial action. | 11/27/09 |

This REQUIREMENT is not met as evidenced by:

Based on observations made on October 6 through 9, 2009 during the tour of dietary services, it was determined that the facility failed to prepare and distribute food under sanitary conditions as evidenced by a soiled outdoor grill stored in the main dining room; a soiled floor in the main kitchen; water leaking from the ceiling in the main kitchen; and hot food temperatures were less than 140 degrees Fahrenheit. These observations were made in the presence of Employee #10.

The findings include:

1. The outdoor grill stored in the main dining room and was observed to be soiled with food residue in one (1) of one (1) outdoor grill observed.

2. The kitchen floor was soiled and in need of cleaning in one (1) of one (1) observation.

3. Water was leaking from the ceiling in the dishwashing area in one (1) of one (1) observation.

4. A test tray was conducted on October 9, 2009 at approximately 1:00 PM. The hot food temperatures were less than the required 140 degrees on the following items:

Fried Catfish was 124 degrees F (Fahrenheit)
Lima beans were 130 degrees F
Green beans were 132 degrees F

These findings were acknowledged by Employee #10 at the time observation.

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| F 431 SS=D | 483.60(b), (d), (e) PHARMACY SERVICES<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and staff interview, it was determined that the facility staff failed to properly | F 431 | 1a. The Xalatan eye drops was discarded and a new bottle of Xalatan eye drops was obtained and dated on 10/7/09.<br>1b. Resident #F1 was not harmed by the deficient practice.<br><br>2.. RCCs checked all residents' medication including eye drops and found them to be in compliance with dating of opened vials on 10/30/09.<br><br>3a. A weekly check of the residents' medications to include eye drops will be conducted by the RCCs to ensure that all medications are labeled and stored properly and per manufactures guidelines.<br>3b. The licensed nurses were re-in-serviced on 10/23/09 on the dating and the administration of multi dose vial medication.<br><br>4. Problems relating to storage, labeling And administration of medication will be reported to DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 431 | Continued From page 27<br>store one(1) of one (1) bottle of Xalatan medication in accordance with the manufacturer's specifications.<br><br>The findings include:<br><br>According to the Manufactures specifications for Xalatan, " ...Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C (77 degrees ) for up to 6 weeks."<br><br>On October 6, 2009 at approximately 3:50 PM, during the inspection of the medication cart, one (1) opened bottle of Xalatan solution was observed in medication cart without an open date.<br><br>A face-to-face interview conducted at the time of the observation with Employee #27. He/she was unable to determine how long the bottle of Xalatan had been opened. And acknowledged that the Xalatan bottle was not dated when opened. | F 431 | | |
| F 454 SS=E | 483.70 PHYSICAL ENVIRONMENT<br><br>The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during an environmental tour of the facility on October 6 and 7, 2009, it was determined that the facility failed to properly maintain the physical environment as required as evidenced by 14 of 50 exhaust vents not functioning properly in resident rooms. The observations were made in the presence of Employee #12. | F 454 | 1. Exhaust vents in residents rooms #17, 119,120,218,219,221,319,320,417,419, 420,517,518, and 520 were restored to service on 10/10/09.<br><br>2. Exhaust vents throughout the facility have been checked by the Director of Maintenance and found to be in compliance.<br><br>3. Exhaust vents will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance. | |

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| F 454 | Continued From page 28<br><br>The findings include:<br><br>1. The exhaust vents were observed not functioning in residents rooms on the west side of the facility in 14 of 50 resident rooms observed. Rooms #117, 119, 120, 218, 219, 221, 319, 320, 417, 419, 420, 517, 518, and 520.<br><br>The findings were acknowledged by Employee #12 at the time of the observations. | F 454 | 4. Deficient practices relating to exhaust vents will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |
| F 469 SS=F | 483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during the recertification survey, it was determined that the facility failed to maintain a pest free environment as evidenced by flying pest observed throughout the entire facility and crawling pests observed on one (1) of five (5) nursing units.<br><br>The findings include:<br><br>1. Flying insects were observed throughout the entire facility during the five (5) day recertification survey.<br><br>2. On one (1) of five (5) nursing units observed, it was determined facility staff failed to maintain a pest free environment as evidenced by the presence of crawling pests. | F 469 | 1a. The 5th floor nursing station was treated for pest control on 10/19/09 by the Western Pest Company.<br>1b. All nursing stations were treated on 10/19/09 and found to be in compliance.<br><br>2. The entire facility was checked and treated for pest control on 11/2/09.<br><br>3a. Facility staff were in-serviced on 10/24/09 to report pest control issues in the pest control log book.<br>3b. Compliance meeting was held with the supervisor from the Western Pest Company on 11/3/09 on plans to control pest in the entire facility **(See attachment V I).**<br><br>3. Problems relating to Pest Control will report to the Director of Environmental Services unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 469 | Continued From page 29 | F 469 | | |
| | On Tuesday, October 6, 2009 at 11:30 AM, a brown crawling pest was observed on the floor at the fifth floor nurses' station.<br><br>On Wednesday, October 7, 2009 at 2:30 PM a brown crawling pest was observed on the 5th floor nurses' station crawling on the desk.<br><br>The findings were made in the presence of Employee #9. | | | |
| F 492 SS=E | 483.75(b) ADMINISTRATION<br><br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to ensure that an annual comprehensive medical examination was conducted for Resident #12.<br><br>The findings include:<br><br>A review of Resident #12's clinical record lacked evidence of an annual comprehensive medical examination for 2009. The record revealed that the last comprehensive medical examination was done on June 24, 2008.<br><br>A face-to-face interview was conducted with Employee #7 at approximately 11:00 AM on | F 492 | 1. The annual comprehensive medical examination (H&P) for resident #12 was later found in the resident's chart on 10/13/09.<br><br>2. All other residents' charts were checked by RCCs and found to have up to date H&Ps on 10/30/09.<br><br>3a. A weekly chart audit will be done by the RCCs to ensure that residents' H&Ps are done in a timely manner.<br>3b. All H&Ps found to be nearing their annual due date or at their annual due date will be flagged by RCCs and the primary physician will be notified so that residents' H&P can be done in a timely manner.<br>3c. Medical records technicians will audit residents' charts monthly for compliance with H&Ps.<br><br>4. Deficient practice related to annual H&P will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 492 | Continued From page 30<br>October 8, 2009. He/she acknowledged that the resident has not received a comprehensive physical for 2009. The record was reviewed on October 7, 2009. | F 492 | | |
| F 514 SS=D | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for three (3) of 26 sampled residents, it was determined facility staff failed to transcribe diet texture orders and accurately document a quarterly dehydration assessment for one (1) resident; accurately screen one (1) resident for mental illness and document interventions and accurately revise the plan of care as it relates to significant weight loss for one (1) resident. Residents #1,12 and 14.<br><br>The findings include:<br><br>1. A review of the clinical record for Resident #1 revealed facility staff failed to accurately document a quarterly dehydration assessment and transcribe diet texture orders onto the current | F 514 | 1a. Resident #1 was re-assessed for dehydration on 10/29/09.<br>1b. Resident showed weight increase in Assessment dated 10/29/09.<br><br>2: All other residents at risk for dehydration were assessed by the RCCs on 11/3/09 using dehydration assessment tool and found to be in compliance.<br><br>3. All residents will be assessed every 3 months, during status change, and on admission for risk for dehydration.<br><br>4. Problems related to residents' dehydration will be reported to the DON, Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for further remedial action | 11/27/09 |

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| F 514 | Continued From page 31<br>physician's orders.<br><br>a.) A review of the significant change Minimum Data Set (MDS) signed March 13, 2009 revealed, Section K3 - weight change; Resident #1 was coded as "weight loss." The resident's weight was documented as 123 pounds. The subsequent quarterly MDS signed June 26, 2009 revealed Section K3-weight change; Resident #1 was coded as "weight loss" with a documented weight of 116 pounds.<br><br>A review of physician's progress notes dated July 15, 22nd, and August 5, 2009 revealed the resident had poor oral intake and his/her weight had declined.<br><br>A review of the quarterly "Dehydration Risk Assessment " revealed assessment dates included March, June and September 2009. In the category labeled "refusal to eat or eating significantly less that the usual amount ", a zero with a line through it was documented, indicating this characteristic did not occur. The category of the assessment allocated for "sudden weight loss (5% or more during the past month)", was documented as "0" (did not occur).<br><br>A face-to-face interview was conducted with Employee #9 on October 6, 2009 at approximately 2:30 PM. In response to a query regarding the accuracy of the Dehydration Risk Assessment, he/she acknowledged that the assessment was inaccurate and failed to capture the weight loss and oral intake decline.<br><br>b.) A review of the most current physician's orders signed August 5, 2009 revealed a therapeutic diet order for low potassium, 2-3 gram | F 514 | 1. The Physician's order for diet texture for Resident #1 (mech soft diet) was transcribed to current physician order on 10/29/09.<br><br>2. All physician orders for residents' diet were reviewed by the RCCs on 11/3/09 and found to be in compliance.<br><br>3a. RCC will review physician orders during monthly turnovers to ensure accuracy in physicians order.<br><br>3b. All residents will be assessed quarterly by IDT members during IDT to ensure proper transcription of orders.<br><br>4. Problems relating to physician dietary orders will be reported to the DON, the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. | 11/27/09 |

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| F 514 | Continued From page 32 | F 514 | | |

sodium restriction. The order lacked evidence of a diet texture.

The record revealed an interim order signed by the physician June 24, 2009 that read, "treatment recommended for dysphagia ...change diet to mechanical soft, thin liquids."

A face-to-face interview was conducted with Employee #9 on October 6, 2009 at approximately 2:30 PM. He/she acknowledged that facility staff failed to transcribe the diet texture onto the current physician's orders. However, he/she provided evidence that the resident received the mechanical soft diet as ordered. The record was reviewed October 6, 2009.

2. Facility staff failed to accurately screen Resident #12 for mental illness and document the correct result of the screening on the evaluation form.

A review of the Evaluation Criteria for Mental Illness/Mental Retardation form revealed that the facility staff's documentation of "no" in response to the question "Does the client have a major mental illness? " was inaccurate.

A review of the annual Minimum Data Sets (MDS) dated August 18, 2008 and September 28, 2009 revealed that the resident was coded for Schizophrenia under section I (Disease Diagnoses) of both Minimum Data Sets.

A review of the Interdisciplinary Team ' s (IDT ' s) Care Plans last updated on October 5, 2009 revealed that the resident ' s care plan for Schizophrenia was last updated on October 5,

1a. Resident #12 was not harmed by the deficient practice.

1b. The MI/MR for the affected resident was completed accurately on 10/13/09 to reflect his current mental health diagnosis.

2. All MI/MRs will be reviewed and audited by Social Workers on11/18/09 to ensure that they reflect each residents mental health diagnosis.

3. The Social Services consultant retrained the Social Workers on 10/30/09 to ensure that information contained in the MI/MR are accurate and up-to-date.

4. Problems related to the accurate completion of the MI/MR will be reported to the Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for remedial action

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| F 514 | Continued From page 33 | F 514 | | |

2009.

A face-to-face interview was conducted with Employee #17 at approximately 1:45 PM on October 13, 2009. He/she acknowledged that the documentation of the resident ' s mental illness screening on the evaluation form was inaccurate. The record was reviewed on October 7, 2009.

3. A review of the clinical record for Resident #14 revealed facility staff failed to document nutritional interventions when it was determined the resident sustained an unplanned significant weight loss and sustained a decline in nutritional/oral intake. Additionally, facility staff failed to accurately revise the resident ' s care plan to address the significant, unplanned weight loss sustained by the resident.

According to the monthly weight record, Resident #14's weight was assessed at 140 pounds for the months of March and April 2009; 138 pounds in June 2009; 124 pounds in August 2009 and 122 pounds in September 2009. The record revealed the resident occasionally refused to have his/her weight assessed and no weights were assessed for the months of January, February, May and July 2009.

a.) According to the quarterly Minimum Data Set (MDS) signed August 13, 2009, Section K3 - weight change, Resident #14 was coded as "weight loss ".

A nutritional progress note dated August 6, 2009 revealed the resident sustained a significant (unplanned) weight loss of 11% in 6 months. The resident ' s oral intake was assessed as good at

1a. A comprehensive nutritional assessment with recommendation was completed on resident #14 by the registered Dietitian on 10/26/09.

1b. All nutritional recommendations for resident #14 were implemented on 10/26/09 and care planned.

2. All residents with significant weight change were checked and reviewed by the dietitian on 10/26/09 and found to be in compliance.

3. The Food Services Director and Dietician will check monthly residents' weights to ensure adequacy of nutrition and proper nutritional documentation for significant changes.

4. Problems related to all significant weight change and nutritional intervention will be reported immediately to the Administrator and will be discussed in the Risk Management/QA and Quarterly QA meetings for further remedial action.

11/27/09

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095031 | A. BUILDING _____ B. WING _____ | 10/13/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROCK CREEK MANOR NURSING CTR | 2131 O STREET NW WASHINGTON, DC 20037 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 514 | Continued From page 34 | F 514 | | |

75-100% of meals consumed. The subsequent nutritional progress note dated September 18, 2009 revealed a significant weight loss of 11% over 4 months and 12% over 7 months. The resident ' s intake had declined from " good " the previous month to " poor - fair " with a meal consumption of 25-50%. Nutritional recommendations included " encourage to be weighed monthly and encourage to eat = 75% of meals.

A face-to-face interview was conducted with Employee #24 on October 13, 2009 at approximately 11:00 AM. In response to a query regarding interventions associated with residents who sustain significant, unplanned weight loss with a decline in meal consumption, he/she stated that nutritional interventions are individualized and may include, but are not limited to weekly weight assessments, calorie counts, nutritional supplements and dietary preferences. In response to a query regarding interventions implemented for Resident #14, he/she stated that a bedtime snack had been initiated and food preferences were obtained and offered in addition to close monitoring of daily meal consumption. He/she acknowledged that the documented nutrition assessments lacked evidence of the aforementioned interventions. The record was reviewed October 8, 2009.

b.) A review of Resident #14's plan of care revealed the interdisciplinary team identified " Therapeutic Diet related to Diabetes Mellitus " as a problem, inclusive of associated interventions and goals.

According to the aforementioned monthly weight record, Resident #14 sustained a significant

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|---|---|---|---|---|
| F 514 | Continued From page 35<br>weight loss between the period of June and August 2009.<br><br>The plan of care was revised on August 6, 2009 and included an entry: " no significant weight changes this quarter, eats good, weight 125 pounds ... " A subsequent care plan revision dated September 18, 2009 revealed an entry, " no significant weight changes, eats poor to fair, weight 122 pounds. "<br><br>The documented care plan revisions of August 6th and September 18, 2009 were inaccurate and conflicted with the nutrition assessments of August and September 2009.<br><br>The findings were review and confirmed by Employee #24 during a face-to-face interview on October 13, 2009 at approximately 11:00 AM. The record was reviewed October 8, 2009. | F 514 | | |