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 _____	11/02/2006

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 PRECEEDED 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 000	INITIAL COMMENTS An annual re-certification survey was conducted October 30 through November 2, 2006. The following deficiencies were based on observations, staff interviews and record reviews. The sample size was 26 residents based on a census of 170 the first day of survey and one (1) supplemental resident.	F 000		
F 241 SS=D	483.15(a) DIGNITY 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. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for one (1) of 26 sampled residents, it was determined that the treatment nurse failed to provide care in a manner which would maintain Resident #17's dignity as evidenced by writing on a dressing which was against the resident's skin. The findings include: A physician's order date October 10, 2006, directed, "Cleanse sacral wound with normal saline. Pat dry and apply Santyl ointment with Polysporin powder BID (twice daily) x 30 days. Cover with Coversite..." A wound treatment observation was conducted on October 31, 2006 at 10:30 AM. At the completion of the treatment, the treatment nurse wrote the date and his/her initials on the taped dressing which was against the resident's skin.	F 241	1a. Resident #17 was not harmed by the deficient practice. 1b. Wound Nurse was immediately corrected not to write on tape after applying to residents. 1c. The nurse was in-serviced to follow the physician's order on wound care. All previous orders were discontinued and a new physician order was obtained for resident # 17. 2a. The wound care nurse technique was monitored by the DON for all residents receiving wound care found be incompliance. 2b. All physicians orders for wound care were checked and were adequately followed.	

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

Administrator 12/12/06

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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F 241	Continued From page 1 A face-to-face interview was conducted with the nurse immediately following the treatment. He/ she stated, "I sign the dressings this way about 90% of the time."	F 241	3a. Wound Nurse will be in-serviced on Wound care protocol 11/24/06. 3b. ADON and Asst. Admin/QA will monitor wound care during weekly wound rounds to ensure Compliance.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey, it was determined that baseboards in the lobby were damaged and recessed into the wall. These findings were observed in the presence of the Directors of Maintenance and Engineering. The findings include: Baseboards in the hallway near dietary services and the lobby elevators were damaged and recessed into the wall in two (2) of two (2) observations between 9:00 AM and 11:00 AM on November 2, 2006.	F 253	4. Problems related to wound care will be discussed in monthly Risk Management meeting, Quarterly QA meeting. Problems will be reported to the Administrator for further remedial action.	11/24/06

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F 241	Continued From page 1 A face-to-face interview was conducted with the nurse immediately following the treatment. He/ she stated, "I sign the dressings this way about 90% of the time."	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey, it was determined that baseboards in the lobby were damaged and recessed into the wall. These findings were observed in the presence of the Directors of Maintenance and Engineering. The findings include: Baseboards in the hallway near dietary services and the lobby elevators were damaged and recessed into the wall in two (2) of two (2) observations between 9:00 AM and 11:00 AM on November 2, 2006.	F 253	1. Baseboards located in the lobby area will be replaced 12/17/06. The Cove base Is obtained by special order. 2. Baseboards throughout the Facility were checked by the Director of Maintenance and Asst. Admin/QA and found to be in compliance. 3a. Baseboards will be checked weekly during Grand Rounds and recorded in the Maintenance log Book to ensure compliance. 3b. The maintenance log is checked daily by the Director of Maintenance for follow-up. 4. Problems related to Cove Base will be discussed in the Monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	12/17/06

2b

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483. 25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483. 10(b)(4). This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 26 sampled residents, it was determined that the dietician failed to develop a care plan for Resident #1's nutritional needs. The findings include: A review of Resident #1's record revealed a physician's order dated June 22, 2006 at 6:30 PM, " ...Foods to omit: breads, rolls, crackers with salted tops, quick breads, self-rising flour and biscuits ...instant hot cereal, commercially prepared rice, pasta and stuffing mixes, regular	F 279	1a. Physician's order for resident#1 nutritional needs was discontinued on 11/2/06. 1b. A new care plan was developed to address resident's current nutritional needs 11/4/06. 2. All resident care plans for appropriate diet have been reviewed and found to be in compliance. 3. Dietary and nursing staff will be in-serviced on resident assessment to reflect the residents' appropriate nutritional needs and plan of care. 4. Problems related to dietary care plans will be discussed at the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	12/15/06

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F 279	Continued From page 3 canned veggies, juice, including sauerkraut and pickled veggies, frozen veggies with sauces, commercially prepared veggie mixes and potatoes and prepared vegetable mixes; fruits processed with salt, malted chocolate milk, regular processed cheese, cheese spreads and sauces, limit buttermilk to one cup per week, any smoked, cured, processed or canned meat, fish and poultry, including bacon, chipped beef, cold cuts, ham, frankfurters, sausages and sardines ... soups ..." Resident #1's meals were observed as follows: October 31, 2006, breakfast: boiled egg, toast, corned beef hash, biscuit, frosted flakes, orange juice, 2% milk, coffee, sugar, jelly, and butter. November 1, 2006, breakfast: boiled egg, toast, frosted flakes, coffee, orange juice. 100% of both meals were consumed. The tray slip, which describes the resident's menu, documented the following, "Diet-no added salt with regular texture." There was no evidence in the record that the dietician developed a care plan to meet Resident #1's nutritional needs. A face-to-face interview with the dietician was conducted on November 1, 2006 at 12:30 PM. He/she acknowledged that there was no care plan and no communication with the kitchen regarding the resident's special diet. The record was reviewed November 1, 2006.	F 279		

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F 309 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by : Sklencar, Mary Based on observation, staff interview and record review for three (3) of 26 sampled residents and one (1) supplemental resident, it was determined that the facility staff failed to update a diet for one (1) resident, include a strength on medication orders for two (2) residents and ensure that the communication logs were complete upon return from the dialysis center, appropriately label medication sent to the dialysis center and send an accurate medication list to the dialysis center for one (1) resident. Residents # 1, 6, 19 and JH 1. The findings include: 1. Facility staff failed to update Resident #1's diet in accordance with a physician's order. A review of Resident #1's record revealed a physician's order dated June 22, 2006 at 6:30 PM, "...Foods to omit: breads, rolls, crackers with salted tops, quick breads, self-rising flour and biscuits ...instant hot cereal, commercially prepared rice, pasta and stuffing mixes, regular canned veggies, juice, including sauerkraut and pickled veggies, frozen veggies with sauces,	F 309	1a. Physician's order for Resident#1 was discontinued. 1b. A new care plan was developed to address resident's current nutritional needs. 1c. Resident is currently on a regular diet. 2. All resident care plans have been reviewed and found to be in compliance with their nutritional needs. 3a. Assistant Administrator/QA will conduct random audits to ensure residents quality of care and compliance. 3b. Dietary and nursing staff will be in-serviced on resident assessment to reflect the residents' quality of care for residents' nutritional needs and plan of care for resident # 1. 4. Problems related to residents assessment and care plans for dietary needs will be discussed at the monthly Risk Management meeting, Quarterly QA meeting and reported to the administrator for Remedial action.	12/15/06

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F 309	Continued From page 5 commercially prepared veggie mixes and potatoes and prepared vegetable mixes; fruits processed with salt, malted chocolate milk, regular processed cheese, cheese spreads and sauces, limit buttermilk to one cup per week, any smoked, cured, processed or canned meat, fish and poultry, including bacon, chipped beef, cold cuts, ham, frankfurters, sausages and sardines ... soups ..." The dietician assessed the resident and recommended a regular diet with no added salt on June 17, 2006. There was no change in the nutritional recommendations after an assessment completed September 13, 2006. There was no evidence in the record that the resident's diet was updated in accordance with the physician's order. A face-to-face interview was conducted with the dietician on November 1, 2006 at 12:30 PM. He/she acknowledged that the current diet does not reflect the resident's physician's order. The record was reviewed November 1, 2006. 2. Facility staff failed to include a strength on the medication orders for Kayexalate and Sorbitol for Resident #6. A review of Resident #6's record revealed a telephone order dated October 2, 2006 at 9:45 AM, "Give Kayexalate 15 ml po (orally) everyday for potassium level and give Sorbitol 15 ml po everyday." The order was signed by the physician on October 3, 2006. The above orders lacked the strength for both medications. The October 2006 Medication Administration Record (MAR) lacked evidence of a strength for	F 309		

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F 309	Continued From page 6 Sorbitol or Kayexalate. According to the October 2006 MAR, the Kayexalate and Sorbitol was administered to the resident from October 3 through 31, 2006 with the exception of October 16 and 30, 2006 when the resident refused the medications. A face-to-face interview was conducted with the unit manager on November 1, 2006 at 8:30 AM. He/she acknowledged that there was no strength indicated for either medication on the physician's order. The record was reviewed November 1, 2006. 3. Facility staff failed to include a strength on the medication order for Ferrous Sulfate for Resident #19. A review of Resident #19's record revealed a telephone order dated August 1, 2006 at 11:30 AM, "Ferrous Sulfate one po Q D (daily) supplement to increase H&H (Hemoglobin and Hematocrit)." The order was signed by the physician on August 7, 2006. The above order lacked a strength for the Ferrous Sulfate. The August, September and October 2006 MARs indicated that the resident was administered Ferrous Sulfate 325 mg one (1) tablet everyday. A face-to-face interview was conducted with the unit manager on November 1, 2006 at 9:40 AM. He/she acknowledged that there was no strength indicated for the medication on the physician's order. The record was reviewed November 1, 2006. 4. Facility staff failed to ensure that the	F 309	1a. Resident # 6 was not harmed by the deficient practice. 1b. The physician's order for Kayexalate and Sorbital for resident #6 was discontinued and a new order was obtained to include the strength of Kayexalate and Sorbital. 1c. Sorbitol is a 70% solution dispensed in quantity only. 2. All residents' charts were reviewed for completeness of medication orders and no other residents' were found to be affected. 3a. All licensed staff will be in-serviced to check for completeness and accuracy of physicians medication orders. 3b. RCC's will review all new physician's medication orders for compliance. 4. Problems with completeness and accuracy of medication orders will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	12/15/06

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F 309	Continued From page 6 Sorbitol or Kayexalate. According to the October 2006 MAR, the Kayexalate and Sorbitol was administered to the resident from October 3 through 31, 2006 with the exception of October 16 and 30, 2006 when the resident refused the medications. A face-to-face interview was conducted with the unit manager on November 1, 2006 at 8:30 AM. He/she acknowledged that there was no strength indicated for either medication on the physician's order. The record was reviewed November 1, 2006. 3. Facility staff failed to include a strength on the medication order for Ferrous Sulfate for Resident #19. A review of Resident #19's record revealed a telephone order dated August 1, 2006 at 11:30 AM, "Ferrous Sulfate one po Q D (daily) supplement to increase H&H (Hemoglobin and Hematocrit)." The order was signed by the physician on August 7, 2006. The above order lacked a strength for the Ferrous Sulfate. The August, September and October 2006 MARs indicated that the resident was administered Ferrous Sulfate 325 mg one (1) tablet everyday. A face-to-face interview was conducted with the unit manager on November 1, 2006 at 9:40 AM. He/she acknowledged that there was no strength indicated for the medication on the physician's order. The record was reviewed November 1, 2006. 4. Facility staff failed to ensure that the	F 309	1a. Resident # 19 was not harmed by the deficient practice. 1b. Telephone order for resident #19, for Ferrous Sulfate without the strength was discontinued and a new order was issued to include the strength of the Ferrous Sulfate. 2. All residents charts were reviewed for completeness and accuracy of medication orders and no other residents' were found to be affected. 3a. All licensed staff will be in-serviced on how to check for completeness and accuracy of physician's medication orders to ensure compliance 12/10/06. 3b. RCCs will review all new physician's orders for compliance. 4. Problems with physician medication orders will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	12/10/06

7A

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F 309	Continued From page 7 communication log was complete upon Resident JH1's return from the dialysis center, appropriately label medication sent to the dialysis center and send an accurate medication list to the dialysis center. The "Rock Creek Manor Nursing Center, Dialysis Communication Logs" [a form used for communication between the nursing center and the dialysis center] dated October 26 and 28, 2006 were reviewed. The communication logs lacked weights, blood pressure readings, lab draws with results, medications administered at dialysis, medication changes/recommendations for new orders and status [of resident]. Additionally, the attached copy of the resident's medication list [sent from the nursing center to the dialysis center] had not been updated to reflect the resident's current medications. The facility staff did not ensure that the dialysis communication logs were completed to reflect the resident's status upon return from the dialysis center. The "Patient Rounding Report" dated October 10, 2006 documented that the resident received Zemplar 5 mcg and Epogen 4400 units at the dialysis center. According to the October 2006 Medication Administration Record (MAR), Resident JH1 goes to dialysis on Tuesday, Thursday and Saturday. The MAR also stipulated that the resident should take Renagel 800mg 4 tablets, three times a day and on dialysis days the lunch dose should be given at the dialysis center. The October 2006 MAR was signed everyday [indicating that the lunch dose for Renagel was given] although the resident was not in the facility at the time.	F 309	1a. Resident #JH1 was not harmed by the deficient practice. 1b. The Dialysis communication log for resident #JH1 was changed to reflect appropriate assessment for pre and post dialysis visits. 2. No other residents other than #JH1is currently attending Dialysis. 3a. Resident information contained on Dialysis Center Rounding Report will be transferred to RCM Pre/Post Dialysis Information Sheet. 3b. Each Dialysis Center Rounding report will also be attached to RCM's Dialysis Report. 3c. Licensed staff will be in-serviced on how to complete and maintain Dialysis Communication Log. RCC's will check communication log daily for appropriate documentation.	

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F 309	Continued From page 8 A telephone interview was conducted on November 9, 2006 at 3:30 PM with the Charge Nurse and the technician at the dialysis center. They stated, "We give him/her Epogen and Zemplar. We are not aware of him/her [Resident #JH1] taking any other medication while here at dialysis. The staff has not observed him/her taking any medications while he/she is here at dialysis." A face-to-face interview was conducted on October 30, 2006 at 3:30 PM with the Resident Care Coordinator (RCC). He/she acknowledged that the dailaysis communication log was incomplete and that there was no documentation that the resident received medication at dialysis. He/she stated that the resident's medication [Renagel 800 mg 4 tablets] was put in a Ziploc bag and labeled with the name of the drug; the name of the drug was hand written by the staff [on the Ziploc bag]. A telephone interview was conducted on November 9, 2003 at 2:55 PM with the Resident Care Coordinator. He/she stated, "It [Renagel 800 mg 4 tablets] was packed, but we were not doing additional labeling." The record was reviewed on October 30, 2006.	F 309		

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 26 sampled residents, it was determined that licensed staff failed to administer a wound treatment according to physician's orders and maintain clean technique during the wound treatment. Resident #17. The findings include: A. The treatment nurse failed to administer a wound treatment according to physician's orders. A physician's order dated October 10, 2006, directed, "Cleanse sacral wound with normal saline. Pat dry and apply Santyl ointment with Polysporin powder BID (twice daily) x 30 days. Cover with Coversite ..." A wound treatment for a Stage IV sacral pressure ulcer was observed on October 31, 2006 at 10:30 AM. The nurse applied a dime size amount of Santyl ointment to a sterile gauze pad. The nurse rubbed the two sides of the gauze pad together to spread the ointment. There was not enough ointment on the gauze pad to cover the wound	F 314	1a. Resident #17 was not harmed by the deficient practice. 1b. The treatment order for resident #17 was changed after verification with the attending physician. 1c. The physician's order for wound care for resident #17 is currently being followed. 2. All medication orders for wound care were reviewed and no deficient practices were noted. 3a. A follow-up formal in-service training will be given to the wound care nurse to include all licensed staff. 3b. The wound care nurse will be monitored during the weekly wound care rounds to ensure that physician's orders are followed for resident #17. 4. Problems related to wound care will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and results reported to the Administrator for remedial action.	On-going 12/15/06

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 314	Continued From page 10 bed. The nurse failed to apply the Polysporin powder. A face-to-face interview was conducted on October 31, 2006 at 10:50 AM with the treatment nurse. He/she stated, "This is the first time I did this treatment and I am working off this sheet [The treatment nurse was using the "Weekly Wound Rounds Report." Documented on the sheet was, "Use Santyl ointment. Cover with 4 x 4 gauze."]. I According to an interview with the Director of Nursing on November 2, 2006 at 2:30 PM, the sheet [Weekly Wound Rounds Report] is utilized during wound rounds for the team to make treatment recommendations. The recommendations are then presented to the physician for review. A face-to-face interview was conducted with the charge nurse on November 2, 2006 at 2:30 PM. He/she stated, "The treatment nurse just started on October 31, 2006. Before that, I did the treatment and used the Santyl and Polysporin ointment." B. The treatment nurse failed to maintain clean technique during the wound treatment. During the wound treatment observation conducted on October 31, 2006 at 10:30 AM, the treatment nurse stated that clean technique would be used and cleansed his/her hands with hand sanitizer, gathered supplies, entered the room and set up the clean field on the resident's bed with the drape partially under the resident's buttock. Wound supplies were opened and	F 314		

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	095031	A. BUILDING _____ B. WING _____	11/02/2006

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F 314	Continued From page 11 placed on the clean field. The nurse donned gloves and removed the soiled dressing. The dressing had a moderate amount of brown drainage with flecks of red. Soiled gloves were removed and clean gloves applied. The nurse cleansed the wound then removed the left hand glove only. A clean glove was donned on the left hand. Medication was applied to 4 x 4 sterile gauze pads and placed over the pressure ulcer. The nurse removed the left hand glove and donned a clean glove. A dressing was applied and secured to the resident with tape. The National Pressure Ulcer Advisory Board, " Frequently Asked Questions, Wound Infection and Infection Control, "web site www.npuap.org/ woundinfection.html".revealed the following: In response to question #309, "Care providers should wash their hands before they remove dressings from the (dressing) package in order to not contaminate the dressings by reaching into the package with soiled hands and/or gloves." According to the Wound Ostomy Continence organization web site: <http://www.o-wm.com>, " Clean technique involves employing methods to reduce the overall number of micro-organisms. Clean technique involves hand washing, preparing a clean field, and using clean gloves and instruments. Clean dressing change may be defined as the replacement of the wound dressing using clean technique and supplies. " A face-to-face interview was conducted on October 31, 2006 at 10:50 AM with the treatment nurse. He/she stated, "I do 90% of my treatments this way. I set up the field on the bed." The nurse did not state why he/she set up the	F 314	1a Resident was not harmed by the deficient practice. 1b. Resident #17 is currently receiving appropriate wound care with respect to applying adequate amount of Polysporin ointment to dressing. 1c. The Wound Care nurse was immediately corrected to use appropriate wound care protocol to include clean technique for resident #17. 2. All residents receiving wound care were assessed and are receiving appropriate wound care treatments. 3a. A follow-up formal in-services training will be given to the wound care nurse. 3b. The Wound Care Nurse's technique will be monitored weekly by the ADON. 3c. All weekend licensed nurses will be inserviced on appropriate wound care protocol to include use of clean technique. 4. Problems related to Wound Care will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and results reported to the Administrator for remedial action.	On-going 12/15/06

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F 314	Continued From page 12 treatment field on the bed.	F 314	1. Over bed lamps in rooms 401, 421, 506, 512, 521 were repaired 11/05/06.	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period for two (2) of five (5) nursing units, it was determined that lamps over residents' beds were not secured into the housing units. These observations were made in the presence of the Directors of Maintenance and Engineering and nursing staff. The findings include: Rooms 401 and 421 on November 1, 2006 between 9:15 AM and 9:30 AM in two (2) of two (2) observations. Rooms 506, 515 and 521 in three (3) of three (3) observations on November 1, 2006 between 10: 12 AM and 11:53 PM.	F 323	2. Over bed lamps in all residents rooms have been checked by the Director of Maintenance and found to be in compliance. 3a. Over bed lamps will be checked weekly by the maintenance staff and during Grand Rounds and recorded in the Maintenance Log Book to ensure compliance. 3b. The Director of Maintenance will ensure immediate correction of any problems identified. 4. Problems related to over bed lamp will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	11/05/06

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F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by : Based on observation and record review for two (2) of 26 sampled residents, it was determined that the physician failed to review telephone medication orders for completeness prior to signing. Residents #6 and 19. The findings include: 1. A review of Resident #6's record revealed a telephone order dated October 3, 2006 at 9:45 AM, "Give Kayexalate 15ml po (orally) everyday for potassium level and give Sorbitol 15 ml po everyday." The physician failed to include a strength for the Kayexalate and Sorbitol prior to signing the telephone order on October 3, 2006. The record was reviewed November 1, 2006. 2. A review of Resident #19's record revealed a telephone order dated August 1, 2006 at 11:30 AM, "Ferrous Sulfate one po Q D (daily) supplement to increase H&H (Hemoglobin and Hematocrit)." The physician failed to include a strength for the Ferrous Sulfate prior to signing the order on August 7, 2006. The record was reviewed November 1, 2006.	F 386	1a. Residents #6 and #19 were not harmed by the deficient practices. 1b. The strength of medications for resident #6 and #19 were included in the physicians order. 2. All resident charts were reviewed for incomplete orders and all were found to be in compliance. 3a. All physicians will be in-serviced on the regulations concerning accurate and completeness of medication orders. 4. Problems related to incomplete physician's orders will be discussed at the monthly Risk Management meeting, Quarterly QA meeting and will be reported to the Administrator for remedial action.	11/22/06

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F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by Based on observation and record review for two (2) of 26 sampled residents, it was determined that the physician failed to review telephone medication orders for completeness prior to signing. Residents #6 and 19. The findings include: 1. A review of Resident #6's record revealed a telephone order dated October 3, 2006 at 9:45 AM, "Give Kayexalate 15ml po (orally) everyday for potassium level and give Sorbitol 15 ml po everyday." The physician failed to include a strength for the Kayexalate and Sorbitol prior to signing the telephone order on October 3, 2006. The record was reviewed November 1, 2006. 2. A review of Resident #19's record revealed a telephone order dated August 1, 2006 at 11:30 AM, "Ferrous Sulfate one po Q D (daily) supplement to increase H&H (Hemoglobin and Hematocrit)." The physician failed to include a strength for the Ferrous Sulfate prior to signing the order on August 7, 2006. The record was reviewed November 1, 2006.	F 386	1a. Resident #6 and #19 were not harmed by the omission of the medication strength. 1b. Order for Kayexalate without the strength for resident #6 was clarified and a new order was obtained to include the strength of the Kayexalate. 2. All residents charts were reviewed for complete orders and no other residents' were found to be affected. 3a. All physicians will be in-serviced on regulations concerning accurate and completeness of medication orders. orders. 3c. RCCs will review all new physician orders for compliance. 4. Problems with physician medication orders will be discussed in the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	11/22/06

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F 429 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing . This REQUIREMENT is not met as evidenced by : Based on observation and record review for two (2) of 26 sampled residents, it was determined that the pharmacist failed to identify and report medication irregularities to the attending physician and the director of nursing. Residents #6 and 19. The findings include: 1. A review of Resident #6's record revealed a telephone order dated October 3, 2006 at 9:45 AM, "Give Kayexalate 15 ml po (orally) everyday for potassium level and give Sorbitol 15 ml po everyday." The order was signed by the physician on October 3, 2006. The pharmacist reviewed the record on September 10 and October 11, 2006. There was no evidence that the pharmacist identified and reported that the medication orders failed to include the strengths for the Kayexalate and Sorbitol. The record was reviewed November 1, 2006. 2. A review of Resident #19's record revealed a telephone order dated August 1, 2006 at 11:30 AM, "Ferrous Sulfate one po Q D (daily) supplement to increase H&H (Hemoglobin and Hematocrit)." The order was signed by the physician on August 7, 2006.	F 429	1a. Residents # 6 and # 19 were not harmed by the deficient practice. 1b. The strength of the medication for resident #6 and resident # 19 were included in the physician order. 2. All medication orders were reviewed by licensed staff and no other residents were affected by the deficient practices. 3a. The Administrator will inform the pharmacist in writing of the importance of the completeness, accuracy of medication review under pharmacy service and will demand a response for the inquiry. 3b. Pharmacy reviews will be monitored by the RCC's for compliance. 4. Problems related to review of Medical orders by the Consulting Pharmacist will be discussed at the monthly Risk Management meeting, Quarterly QA meeting and reported to the Administrator for remedial action.	11/22/06

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F 429	Continued From page 15 The pharmacist reviewed the record September 20 and October 11, 2006. There was no evidence that the pharmacist identified or reported that the medication order failed to include the strength for the Ferrous Sulfate. The record was reviewed November 1, 2006.	F 429		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period for three (3) of five (5) nursing units, it was determined that the facility failed to maintain a sanitary environment as evidenced by: oxygen concentrators soiled with dust, ice scoops stored on top of ice chests and cleaning equipment stored on the floor of the janitorial closet. The findings include: 1. Oxygen concentrators were observed with dust on the interior surfaces behind the filter in rooms	F 441	1a. Related residents were assessed by a licensed nurse and no respiratory problems relating to infection was found. 1b. The oxygen concentrators in rooms 301, 302 found to be soiled were replaced with clean concentrators 11/14/06. 1c. No oxygen concentrator in room 215. Room 315 instead. 2. All soiled oxygen concentrators were removed from the units and sent out to be cleaned by an outside contractor. 3. The interior of oxygen concentrators will be cleaned annually by Roberts as indicated in our oxygen concentrator service agreement.	

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F 429	Continued From page 15 The pharmacist reviewed the record September 20 and October 11, 2006. There was no evidence that the pharmacist identified or reported that the medication order failed to include the strength for the Ferrous Sulfate. The record was reviewed November 1, 2006.	F 429		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period for three (3) of five (5) nursing units, it was determined that the facility failed to maintain a sanitary environment as evidenced by: oxygen concentrators soiled with dust, ice scoops stored on top of ice chests and cleaning equipment stored on the floor of the janitorial closet. The findings include: 1. Oxygen concentrators were observed with dust on the interior surfaces behind the filter in rooms	F 441	4. Problems related to oxygen concentrators will be discussed at the monthly Risk Management meeting, Quarterly QA meeting. problems will be reported to the Administrator for remedial action.	11/14/06

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F 441	Continued From page 16 215, 301 and 302 in three (3) of three (3) observations on October 31, 2006 between 9:28 AM and 1:40 PM. 2. Ice scoops were observed on units 2 and 5 stored on top of the ice chest and soiled in two (2) of five (5) observations on November 1, 2006 between 9:40 AM and 10:20 AM. 3. Cleaning equipment, such as mops, brooms and dustpans, was stored on the floor of the janitorial closet and soiled utility room on unit 3 in two (2) of two (2) observations on October 31, 2006 at 3:10 PM.	F 441	1a. No resident was harmed by the deficient practice. 1b. The Ice Scoop was sanitized immediately and placed in the scoop holder. 2. All other ice scoops were checked and found to be in compliance. 3. Team leaders, RCCs and ADON will be in-serviced on making daily rounds to ensure ice scoops are stored properly in the ice bins.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS 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. 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. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) supplemental resident, it was determined that facility staff failed to ensure that the dialysis communication logs were complete upon the	F 514	4. Problems related to the ice scoop storage will be discussed at the monthly Risk Management meeting, Quarterly QA meeting. Problems will be reported to the Administrator for remedial action.	12/15/06

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F 441	Continued From page 16 215, 301 and 302 in three (3) of three (3) observations on October 31, 2006 between 9:28 AM and 1:40 PM. 2. Ice scoops were observed on units 2 and 5 stored on top of the ice chest and soiled in two (2) of five (5) observations on November 1, 2006 between 9:40 AM and 10:20 AM. 3. Cleaning equipment, such as mops, brooms and dustpans, was stored on the floor of the janitorial closet and soiled utility room on unit 3 in two (2) of two (2) observations on October 31, 2006 at 3:10 PM.	F 441		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS 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. 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. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) supplemental resident, it was determined that facility staff failed to ensure that the dialysis communication logs were complete upon the	F 514	1a. Resident #JH1 was not harmed by the deficient practice. 1b. The physicians order for Renagel was discontinued and a new order obtained to administer the Renegal in the facility before and after Dialysis. 2a. No other resident than #JH1 is currently attending Dialysis or was affected by the deficient practice. 3a. Nursing staff will be in-serviced on regulations regarding labeling of medication, dispensing of medication and medication pass.	

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F 514	Continued From page 17 resident's return to the facility and that the Medication Administration Record accurately reflected the administration of Renagel. Resident JH1. The findings include: The "Rock Creek Manor Nursing Center, Dialysis Communication Logs" [a form used for communication between the nursing center and the dialysis center] dated October 26 and 28, 2006 were reviewed. The communication logs lacked weights, blood pressure readings, lab draws with results, medications administered at dialysis, medication changes/recommendations for new orders and status [of resident]. Additionally, the attached copy of the resident's medication list [sent from the nursing center to the dialysis center] had not been updated to reflect the resident's current medications. The facility staff did not ensure that the dialysis communication logs were completed to reflect the resident's status upon return from the dialysis center. The "Patient Rounding Report" dated October 10, 2006 documented that the resident received Zemplar 5 mcg and Epogen 4400 units at the dialysis center. According to the October 2006 Medication Administration Record (MAR), Resident JH1 goes to dialysis on Tuesday, Thursday and Saturday. The MAR also stipulated that the resident should take Renagel 800mg 4 tablets, three times a day and on dialysis days the lunch dose should be given at the dialysis center. The October 2006 MAR was signed everyday [indicating that the lunch dose for Renagel was given] although the resident was not in the facility	F 514	3b. RCC's and ADON will monitor to ensure that medications are not labeled and dispensed by staff to include medication pass. 4. Problems related to labeling and dispensing of medication by staff will be discussed in Monthly Risk Management meeting, Quarterly QA meeting, and Problems will be reported to the Administrator for remedial action.	12/10/06

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F 514	Continued From page 18 at the time. A telephone interview was conducted on November 9, 2006 at 3:30 PM with the Charge Nurse and the technician at the dialysis center. They stated, "We give him/her Epogen and Zemplar. We are not aware of him/her [Resident #JH1] taking any other medication while here at dialysis. The staff has not observed him/her taking any medications while he/she is here at dialysis." A face-to-face interview was conducted on October 30, 2006 at 3:30 PM with the Resident Care Coordinator (RCC). He/she acknowledged that the dialysis communication log was incomplete and that there was no documentation that the resident received medication at dialysis. He/she stated that the resident's medication [Renagel 800 mg 4 tablets] was put in a Ziploc bag and labeled with the name of the drug; the name of the drug was hand written by the staff [on the Ziploc bag]. A telephone interview was conducted on November 9, 2003 at 2:55 PM with the Resident Care Coordinator. He/she stated, "It [Renagel 800 mg 4 tablets] was packed, but we were not doing additional labeling." The record was reviewed on October 30, 2006.	F 514		