STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	098028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3000 MILITARY ROAD NW WASHINGTON, DC 20015

(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 000	INITIAL COMMENTS A follow-up survey (to the re-certification survey on September 24 through September 26, 2007) was conducted on November 19, 2007. The following deficiencies were based on record review, observations and staff interviews. The sample size was nine (9) residents based on 60% of the standard survey sample for 68 residents and seven (7) supplemental residents.	F 000		
{F 253} BS=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 environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: soiled ceiling tiles and marred and/or damaged furniture. These observations were made in the presence of Employees #2 and 6 on November 19, 2007 between 9:00 AM and 10:30 AM. These were repeat deficiencies from the annual re-certification survey completed September 26, 2007. The findings include: 1. Soiled ceiling tiles were observed in the lower level dayroom, dining room and lower level pantry. 2. Furniture marred, worn and/or damaged was observed in the following areas: Six (6) of six (6)	{F 253}	1. No residents were affected. • Soiled ceiling tiles observed in the lower level day room dining room and lower level pantry were replaced. • Observered marred, worn and/ or damaged furniture was refinished, removed or replaced 11/30/2007 2. Environmental Rounds were conducted 12/06/2007 and no other deficiencies were noted. 3. The Maintenance Supervisor or designee will conduct monthly preventive maintenance rounds. All work generated will be completed within 48-72 hours with written affirmation. 4. The facility management director will conduct random audits and will be presented monthly to the QA committee.	12/24/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 12/12/07

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 253}	Continued From page 1 arm chairs in the first floor dayroom and two (2) of two (2) arm chairs on the first floor across from the nursing station area.	{F 253}		
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 staff interview and record review for one (1) of nine (9) sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for Resident #3's use, monitoring and effectiveness of pain medication. The findings include:	F 279	1. A Comprehensive Pain Care Plan was put in place for resident #3. 12/06/07 2. All residents on pain management will have a Care plan initiated or updated for pain management. 12/06/07 3. Monthly audits of pain care plans will be conducted by the Unit Manager or designee. On going 4. A report of the audits will be submitted to the QA committee monthly and recommendations. 12/26/2007 /On going 12/26/2007	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 279	Continued From page 2 A review of Resident #3's record revealed an "Interim Order" dated October 15, 2007, at 6:00 PM directing, " ...Start with Fentanyl patch 25 mcg/hr, apply patch topically to skin every 72 hours starting today". A review of the November 2007 Medication Administration Record revealed that Resident #3 received the Fentanyl patch as per the physician's order. A review of the record lacked evidence that a care plan was initiated to include appropriate goals and approaches to address the resident ' s use of the Fentanyl patch for pain. A face-to-face interview was conducted with Employee #8 on November 19, 2007 at 2:20 PM. He/she acknowledged that a care plan was not initiated for pain. The record was reviewed November 19, 2007.	F 279		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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. 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	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 280}	Continued From page 3 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of nine (9) sampled residents, it was determined that facility staff failed to update the wound care plan with appropriate goals and approaches for Resident #4's current skin condition. The findings include: A review of Resident #4's "Wound Documentation" form revealed, "...Date wound first discovered: September 15, 2007; Wound location: Anal Abscess; Date: November 5, 2007- wound size 2.75 x 2.25 x 0.4 cm, November 12, 2007- wound size 2.25 x 2.0 x 0.2 cm". A review of the "Wound" care plan initiated and last updated September 12, 2007 was not updated to include appropriate goals and approaches to address the resident's current skin condition. A face-to-face interview was conducted with Employee #8 on November 19, 2007 at 2:10 PM. He/she acknowledged that the"Wound" care plan was not updated to include the resident's current skin condition. The record was reviewed November 19, 2007.	{F 280}	1. Resident # 4 wound care plan was updated. 2. All residents with wounds will have a care plan Initiated and/or updated by 12/26/2007. 3. The unit manager or designee will do random wound care plan audits monthly to insure care plans are updated with appropriate goals and approaches are in place. 4. Report of the audits will be submitted to the Q.A committee monthly for review and recommendations by 12/26/2007 / on going.	On going 12/26/2007
F 309 SS=D	483.25 QUALITY OF CARE	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 309	Continued From page 4 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: Based on observation, staff interview and record review for one (1) of nine (9) sampled residents, it was determined that facility staff failed to clarify the documentation of a morphine allergy for Resident #4 prior to administering the medication. The findings include: A review of the physician's telephone order sheet dated September 1, 2007 revealed , "Allergies:...Morphine..." A review of Resident #4's record, revealed a physician's telephone order dated September 22, 2007 at 2:20 PM and signed by the physician on October 4, 2007 that directed, "Morphine Sulfate 10 mg/5ml, give 7.5 ml PO [by mouth Q4HRS [every four hours] PRN [as needed] for Rectal Pain/ moderate pain of any source". An "Interim Order" dated and signed by the physician on November 17, 2007 directed, "...Morphine (20 mg/ml) 2.5 mg po [by mouth] q 8 h [every 8 hours] scheduled (pain)..." A review of the Medication Administration Record for November 2007 revealed, "Allergies:...Morphine..." and that the Resident #4 received Morphine Sulfate 10 mg on November 9,	F 309	1. After confirming with resident # 4's family and consulting with the attending MD, the morpheria allergy was removed from the record. 2. All residents with allergies recorded on the medical record will be reviewed to insure that they are not receiving medications listed as allergies. 3. Monthly chart audits will be completed by the unit Manager and or designee to insure compliance With Allergies listed on the medical record. 4. Report of the audits will be submitted to the QA Committee for review and recommendation by 12/26/2007/ On going.	11/20/2007 12/26/2007 On going 12/26/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 309	Continued From page 5 12, 14, 15, 17 and 18, 2007. The record lacked evidence that the facility staff clarified the order for morphine prior to the resident receiving the medication. Resident has had no untoward effects from receiving the Morphine. A face-to-face interview was conducted with Employee #8 on November 19, 2007 at 2:10 PM. He/she reviewed the resident's record and stated, "We need to clarify this allergy. I don't know where that came from. It just appeared on the September POS (Physician's Order Sheet). The resident has not had any problems since he/she has been taking this medication." The record was reviewed November 19, 2007.	F 309		
{F 323} SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to: conduct hourly resident rounds, replace damaged skid strips, secure laundry detergent and oxygen tanks and remove medications found at a resident's bedside. The findings include:	{F 323}	1. A) Hourly round will be put in place for those residents that are identified as frequent fallers. 2. All residents identified as frequent fallers will be monitored hourly. 12/10//2007/ on Going 3. All falls will be reviewed by the Falls Committee to identify frequent fallers and to insure that the frequent faller protocol is followed. 12/26/2007 /on going. 4. The DON will present Falls Committee recommendations to the QA committee monthly. B1) The skid strips in the shower room on the first floor level were replaced and the surrounding area cleaned. C1) The container of laundry detergent that was Observed unsecured on the floor in room 188 was removed. D1) The oxygen room door on the upper and Lower levels were locked. The upper level Oxygen tanks were secured.	12/10/07 On going on going On going 11/30/07 11/19/2007 11/20/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 323}	Continued From page 6 1. Facility staff failed to conduct hourly resident rounds are per the Plan of Correction for the annual re-certification survey completed September 26, 2007. According to the plan of correction for the annual re-certification survey completed September 26, 2007, "Nursing Staff will be required to do rounds and document rounding times. Licensed nursing staff will do rounds hourly to insure [bed/chair] alarms are in place and residents are safe." The completion dated was November 9, 2007. Hourly round sheets were reviewed for November 9 through 19, 2007 for both the upper and garden levels. According to the forms, hourly rounds were to be completed from 7:00 AM through 7:00 PM and half-hour rounds were to be completed from 7:00 PM through 7:00 AM. Documentation for hourly rounds was inconsistent for all shifts on both the garden and upper levels from November 9 through 19, 2007. A face-to-face interview was conducted with Employee #6 on November 9, 2007 at 4:30 PM. He/she stated, " The round sheets were our response to the frequent fallers. All the nursing staff was in-serviced on the implementation of the hourly round sheets. " Employee #6 acknowledged that the hourly round sheets were not completed from November 9 through 19, 2007. 2. The skid strips on the shower room on the first floor level were observed to be damaged and did not adhere to the shower floor.	{F 323}	E1) Medications that were observed on the residents bedside table and overbed table were removed. 2. All resident rooms and common areas have been checked for environmental hazards (medication, detergent etc.). Any deficient practice has been reported to the appropriate department to be resolved. 3a. All Health Care staff will be educated on maintaining an accident free environment and how to report any issues that require attention from other departments. b. The Safety committee will do monthly rounds to Monitor unsafe conditions in the health care center. 4. The safety committee will present monthly rounds findings to the QA committee for review and recommendations. ongoing	11/20/2007 11/30/2007 11/30/2007 On Going 12/26/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 323}	Continued From page 7 3. A container of laundry detergent was observed unsecured on the floor in room 188. 4. The oxygen room door on the upper and lower levels were unlocked. Additionally, the upper level oxygen room contained three (3) of five (5) oxygen tanks that were observed unsecured. 5. Treatment medications [Lidocaine Hcl 2% and one (1) box of hemorrhoidal suppositories] were observed on the resident's bedside table and overbed stand in room 191 in one (1) of 20 rooms observed. The environmental tour was conducted on November 19, 2007 between 8:30 AM and 10:30 AM in the presence of Employees #2 and 6. Employees #2 and 6 acknowledged the above findings at the time of the observations. Items #2, 3, 4, and 5 were repeat deficiencies.	{F 323}		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 329	Continued From page 8 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of nine (9) sampled residents, it was determined that the physician prescribed Haldol for Resident #1 without adequate indication for its use. The findings include: A review of Resident #1's record, revealed a physician's telephone order dated November 11, 2007 at 6:00 PM that directed, "Haldol 0.5 mg po (orally) every 6 hours as needed for agitation." The nurses' notes were reviewed from November 9 through 19, 2007. There was no evidence in the nurses' notes that the resident had an episode of agitation. A review of the Medication Administration Record for November 2007 revealed the resident did not receive Haldol since it was ordered on November 11, 2007. The physician completed the admission history and physical examination on November 7, 2007. There was no clinical rationale in the history and physical examination for the use of Haldol. There was no evidence that the physician had seen the	F 329	1. The Haldol was discontinued for resident #1 2. All residents on psychotropic drugs will be reviewed to insure that there is a specific diagnosis documented in the clinical record. 3. The unit manager in consultation with the Pharmacy will review monthly those residents on Psychotrophic meds to insure a diagnosis is in place for anti psychotropic use. 4. Audit results will be submitted to the QA Committee for review and recommendation by 12/24/2007 / On going.	11/31/2007 12/10/2007 On Going 12/26/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 329	Continued From page 9 resident after November 7, 2007. A face-to-face interview was conducted with Employee #1 on November 19, 2007 at 11:00 AM. He/she reviewed the resident ' s record and stated, "Why is [he/she] on Haldol? That's not right. [He/she] is not a behavior problem. I'll call the doctor now." The record was reviewed November 19, 2007.	F 329		
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 staff interview and record review for one (1) of nine (9) sampled residents, it was determined that the physician failed to review Resident #4's medications and allergies prior to prescribing Morphine. The findings include: A review of the physician's telephone order sheet dated September 1, 2007 revealed , "Allergies:...Morphine..." A review of Resident #4's record, revealed a physician's telephone order dated September 22, 2007 at 2:20 PM and signed by the physician on	F 386	1. After confirming with resident #4'S family and consulting with the attending physician, the M.S. allergy was removed from the record. 11/20/2007 2. All residents with allergies recorded on the medical record will be reviewed to insure that they are not receiving medications listed as allergies. 11/30/2007 3. The Medical Director will review with facility attending physician their responsibility in reviewing the medical record to insure the safety of orders. 12/26/2007 The Medical Director or designee will do a random monthly audit on going to insure physician compliance. On going 4. Audits will be submitted to the QA committee for review and recommendation by 12/26/2007 On going. 12/24/2007	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 386	Continued From page 10 October 4, 2007 that directed, "Morphine Sulfate 10 mg/5ml, give 7.5 ml PO [by mouth Q4HRS [every four hours] PRN [as needed] for Rectal Pain/ moderate pain of any source". An "Interim Order" dated and signed by the physician on November 17, 2007 directed, "...Morphine (20 mg/ml) 2.5 mg po [by mouth] q 8 h [every 8 hours] scheduled (pain)..." A review of the Medication Administration Record for November 2007 revealed, "Allergies:...Morphine..." and that Resident #4 received Morphine Sulfate 10 mg on November 9, 12, 14, 15, 17 and 18, 2007. The record lacked evidence that the physician identified that Resident #4 had a documented allergy to morphine prior to prescribing the drug. Resident has had no untoward effects from receiving the Morphine. A face-to-face interview was conducted with Employee #8 on November 19, 2007 at 2:10 PM. He/she reviewed the resident's record and stated, "We need to clarify this allergy. I don't know where that came from. It just appeared on the September POS (Physician's Order Sheet). The resident has not had any problems since [he/she] has been taking this medication." The record was reviewed November 19, 2007.	F 386		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 425	Continued From page 11 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for two (2) of nine (9) sampled residents and seven (7) supplemental residents, it was determined that facility staff failed to: remove expired or discontinued medications from the medication carts and/or the medication refrigerators. Residents #2, 4, M1, M2, M3, M4, M5, M6, and M7. The findings include: The medication carts on the upper and lower levels were inspected and the following expired, discontinued, unlabeled and/or undated medications were observed on November 19, 2007 from 8:15 AM through 11:00 AM as follows: Upper Level 1. Four (4) bags of intravenous Zyvox (antibiotic) for Resident #2 was observed in the medication	F 425	1. All expired, discontinued, unlabeled and /or Undated medications for residents # 2, 4, M1, M2, M3, M4, M5, M6 & M7 have been discarded or labeled and dated. 2. All medications carts will be inspected by the unit manager or designee for unlabeled , discontinued and undated meds. 3. The licensed nurses will be re- educated on expired and undated medications. The Nurse Supervisor will do a random weekly Medication cart audits to insure compliance. 4. Audits will be submitted to the QA committee for review and recommendation by 12/26/2007/ on going.	11/21/2007 11/21/2007 On going 12/26/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 425	Continued From page 12 refrigerator. The order for Zyvox was discontinued on November 9, 2007. 2. One (1) tube of Gentamycin Sulfate ophthalmic antibiotic was observed in the medication cart for Resident #4. The order was written on October 29, 2007 to instill the medication to both eyes for 5 days. The administration of the medication was completed November 2, 2007. 3. One (1) tube of Tobradex ophthalmic ointment for Resident M1 was observed in the medication cart and had a pharmacy fill date of March 14, 2007. The medication was not renewed on the Physician's Order Sheet (POS) signed by the physician on June 7, July 12, August 9, and October 4, 2007. 4. One (1) bottle of Deep Sea Nasal Spray for Resident M2 was observed in the medication cart and had a pharmacy fill date of July 15, 2007. The medication was not renewed on the POS signed by the physician on August 13, September 5 and October 25, 2007. 5. One (1) bottle of ear drops (Debrox) for Resident M3 was observed in the medication cart and had a physician's order dated September 11, 2007, " Instill 4 gtts (drops) to right ear daily x 7 days. " 6. One (1) tube of Bacitracin and one (1) tube of Triple Paste (antibiotic ointment) for Resident M4 were observed in the medication cart. The resident was sent to the hospital on September 20, 2007 and expired in the hospital. Lower Level	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 425	Continued From page 13 7. One (1) bottle of ear drops (Debrox) for Resident M5 was observed in the medication cart. There was a physician's order to discontinue the ear drops on September 5, 2007. 8. Two (2) bottles of Caltrate 600 for Resident M6 was observed in the medication cart and had a fill date from the pharmacy of May 21, 2007. The medication was not renewed on the POS signed by the physician on June 25, August 30, October 18 and November 2, 2007. 9. One (1) bottle of Cosopt Occumeter Plus for Resident M7 was observed in the medication cart and had a pharmacy fill date of September 9, 2007. The medication was not renewed on the POS signed by the physician on September 27 and November 1, 2007. 10. One (1) of seven (7) tubes of Glutose 15, a glucose paste for hypoglycemic reactions had an expiration date of June 20, 2007. 11. Two (2) bottles of Nystop (Nystatin powder) were observed in the medication cart opened and without a pharmacy label. One (1) bottle had a manufacturer's expiration date of March 2006. Employee #10 discarded the Nystop with the expiration date of March 2006. A face-to-face interview was conducted with Employees #9 (upper level) on November 19, 2007 at 8:30 AM and Employee #10 (lower level) on November 19, 2007 at 9:30 AM, after the medication carts were inspected. Both employees acknowledged the above findings at the time of the inspection.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 428	Continued From page 14 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of nine (9) sampled residents, it was determined that the pharmacist failed to identify and report that Resident #4, who had a documented allergy to Morphine, was prescribed the medication. The findings include: A review of the physician's telephone order sheet dated September 1, 2007 revealed , "Allergies:...Morphine..." A review of Resident #4's record, revealed a physician's telephone order dated September 22, 2007 at 2:20 PM and signed by the physician on October 4, 2007 that directed, "Morphine Sulfate 10 mg/5ml, give 7.5 ml PO [by mouth Q4HRS [every four hours] PRN [as needed] for Rectal Pain/ moderate pain of any source". An "Interim Order" dated and signed by the physician on November 17, 2007 directed, "...Morphine (20 mg/ml) 2.5 mg po [by mouth] q 8 h [every 8 hours] scheduled (pain)..."	F 428	1. After confirming with resident # 4's family and Consulting with the attending physicians the morphine allergy was removed from the record. 2. All residents with allergies recorded on the Medical record will be reviewed to insure that they are not receiving medications listed as allergies. 3. The DON will review with the pharmacist the error regarding the order for MS for the resident with an allergy to the medication. 4 Report of the audits will be submitted to the QA committee monthly x3 for review and recommendations. Jan. Feb. & Mar.2008	11/20/2007 11/20/2007 12/07/207 12/24/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 428	Continued From page 15 A review of the Medication Administration Record for November 2007 revealed, "Allergies:...Morphine..." and that the Resident #4 received Morphine Sulfate 10 mg on November 9, 12, 14, 15, 17 and 18, 2007. According to the "Medication Regimen Review" conducted on November 15, 2007, the pharmacist reviewed the record and found that "Based upon the information available at the time of the review...no new irregularities..." The record lacked evidence that the pharmacist identified that Resident #4's was prescribed morphine and had a documented allergy to the drug. The resident has had no untoward effects from receiving the Morphine. A face-to-face interview was conducted with Employee #8 on November 19, 2007 at 2:10 PM. He/she reviewed the resident's record and stated, "We need to clarify this allergy. The resident has not had any problems since he/she has been taking this medication." The record was reviewed November 19, 2007.	F 428		
{F 431} SS=F	483.60(b), (d), (e) PHARMACY SERVICES 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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 431}	Continued From page 16 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to label or date medication containers/vials when opened. The findings include: The medication carts and refrigerators on the upper and lower levels were inspected and the following unlabeled and/or undated medications were observed on November 19, 2007 from 8:15 AM through 11:00 AM as follows: 1. Eight (8) of 14 bottles of insulin were observed without an open date on the upper and lower level	{F 431}	1. All bottles of insulin currently refrigerated have labels. 11/19/2007 The two bottles of Nystatin powder observed were discarded 11/19/2007. The one bottle of Tuberculin purified protein Derivative was discarded 11/19/2007. 2. The Nurse Supervisior or desiginee on each unit reviewed each med carts and unit refrigerator to insure all open medication were dated and appropriate labels in place, discharge medications removed from cart. 3. The Nurse Supervisors will do random audits weekly to look for unlabeled medications, undated meds and expired meds. 4. Audits will be submitted to the QA committee for review and recommendation by 12/26/2007 on going.	on going 12/26/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 431}	Continued From page 17 refrigerators. 2. Two (2) bottles of Nystop (Nystatin powder) were observed in the medication cart opened and without a pharmacy label. Employee #10 returned the unlabeled Nystop that expired November 2008 to the medication cart. 3. One (1) bottle of Tuberculin Purified Protein Derivative was observed in the refrigerator and had an open date of September 7, 2007. According to the manufacturer's recommendation on the box containing the vial was "Discard after 30 days of being opened." A face-to-face interview was conducted with Employees #9 (upper level) on November 19, 2007 at 8:30 AM and Employee #10 (lower level) on November 19, 2007 at 9:30 AM, after the medication carts were inspected. Both employees acknowledged the above findings at the time of the inspection.	{F 431}		
{F 441} SS=D	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:	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 441}	Continued From page 18 Based on observation and staff interview for two (2) of two (2) wound treatments observed, it was determined that facility staff failed to maintain infection control procedures to prevent the spread of disease during wound treatments. Residents #2 and 4. The findings include: Resident #2 was on isolation precautions for MRSA [Methicillin-Resistant Staphylococcus aureus] to the left BKA [below the knee amputation] as per readmission orders signed by the physician on November 6, 2007. On November 19, 2007 at 11:20 AM during a wound treatment it was observed that the treatment carry caddy was placed on a towel on the resident's bedside table. Employee #9 removed the soiled dressing from Resident #2's left leg. He/she proceeded to take supplies such as wound cleanser, 4 x 4 gauze sponges, stretch/wrap gauze and paper tape out of the treatment carry caddy to use to dress the resident's wound. Employee #9 placed the soiled dressings in a non-biohazard trash bag into the beige trash receptacle in the resident's room. At the completion of the wound treatment, the trash receptacle was placed in the resident's bathroom and the non-biohazard trash bag was not closed. He/she carried with the treatment carry caddy to Resident #4's room. At 11:35 AM on November 19, 2007 Employee #9 entered Resident #4's room. He/she placed the treatment carry caddy on top of pillows in a chair. Employee #9 put the treatment supplies on Resident #4's overbed table. He/she did not clean the overbed table before setting the permeable	{F 441}	1. Resident # 2 and 4 wounds were re- inspected to Insure that the wound treatments were adequate. 2. The Staff Development coordinator observed the technique of wound dressing done by charge nurses on a all residents with wounds. 3. All licensed nursing staff were re- educated on infection control procedures with emphasis on dressing changes. The Staff Development Coordinator will do Random dressing change audits with licensed staff times 90 days. This is to include agency staff. 4. The Staff development Coordinator will present the Audits to the QA committee monthly X 3 for review and recommendations. Jan. Feb. & Mar. 2008	12/24/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 441}	Continued From page 19 towel and supplies on the table. He/she proceeded to conduct the wound treatment using supplies [wound cleanser, 4 x 4 gauze sponges] that were in the treatment carry caddy. An observation of the treatment carry caddy was conducted on November 19, 2007 at 12:10 PM. The caddy contained one (1) bag of 4 x 4 gauze sponges, one (1) bag of stretch bandage, one (1) bottle of wound cleanser, two (2) rolls of paper tape, one (1) pair of scissor, and other creams and ointments that belonged to five (5) additional residents. A face-to-face interview with Employee #9 was conducted on November 19, 2007 at 12:15 PM. He/ She acknowledged that he/she brought the treatment carry caddy containing other resident's treatment medications and supplies into the isolation room, did not remove the infectious waste from the room and brought the treatment caddy into another resident's room after leaving an isolation room.	{F 441}		
F 492 SS=D	483.75(b) ADMINISTRATION 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of staffing schedules, it was determined that nursing administration failed to ensure that nursing staff had current copies of	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 492	Continued From page 20 licenses/certifications on file in the Human Resources Department (HRD). The findings include: _ _ According to 22DCMR 3203.2, "A list of employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director." A review of the plan of correction to the annual licensure survey completed September 26, 2007 revealed that HRD would maintain current nursing licenses and certifications. A face-to-face interview was conducted with Employee #5 on November 9, 2007 at 3:30 PM. He/she stated, "Two (2) notices had been included in two (2) different nursing pay checks asking for nursing licenses and certifications to be in the HRD by September 28 and November 15, 2007. We still don't have a copy of all the nursing licenses. There are six (6) RNs (registered nurses), 14 LPNs (Licensed Practical Nurses) and 19 CNAs (Certified Nurse Aides) that we don't have a copy of their licenses or certifications. We have verification of a current license but not a copy of the license itself." An interview with Employee #1 was conducted on November 19, 2007 at 3:45 PM. He/she stated, "The people who did not give HRD their license or certification were taken off the schedule." Staffing was reviewed from November 9 through 19, 2007. Six (6) RNs failed to provide current copies of their license to HRD and worked at least two (2) shifts from November 9 through 19, 2007. Seven (7) CNAs failed to provide current copies	F 492	1. No resident was affected by this deficiency. All RN's,LPN's and C.N.A's currently Employed were required to submit a current copy of their license or certification to the Human Resourses department immediately. 2. All licensed staff and C.N.A's employment Records were audited for current licenses by the Human Resources Director or designee. Any licensed staff or C.N.A's found not to have A current license or certification on file will be removed from the staffing schedule. 3. The H.R. Director or designee will review/ audit the renewal dates of the licensed nursing staff and c.n.a's employed by the facility monthly. 4. Results of this audit will be presented to the QA committee monthly times three Nov., Dec., & Jan. 2008.	12/24/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	R 11/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 492	Continued From page 21 of their certification to HRD worked at least one (1) shift from November 9 through 19, 2007.	F 492		