PRINTED: 11/06/2008 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI			(X3) DATE SURVEY COMPLETED		
			B. WING				R
		095028	D. WIN		· · · · · · · · · · · · · · · · · · ·	10/2	9/2008
NAME OF PROVIDER OR SUPPLIER			·	3	REET ADDRESS, CITY, STATE, ZIP CODE 1050 MILITARY ROAD NW VASHINGTON, DC 20015		ſ
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 000} {F 157} SS=D	conducted to the ani was concluded on A deficiencies were bar resident interviews a On October 28-29, 2 483.10(b) (11) NOTH A facility must imme consult with the resident's interested family me involving the resident's interested family me involving the resider the potential for requisignificant change in or psychosocial state mental, or psychoso threatening condition need to alter treatmed discontinue an existi adverse consequent form of treatment); c discharge the resider in §483.12(a). The facility must also and, if known, the re- interested family me room or roommate a §483.15(e)(2); or a c Federal or State law paragraph (b)(1) of The facility must rec- address and phone for	008 a follow-up survey was nual re-certification survey that ugust 11, 2008. The following sed on observations, staff and ind record review. 008 a follow-up survey was FICATION OF CHANGES diately inform the resident; dent's physician; and if known, legal representative or an mber when there is an accident at which results in injury and has uiring physician intervention; a the resident's physical, mental, us (i.e., a deterioration in health, cial status in either life hs or clinical complications); a ent significantly (i.e., a need to ing form of treatment due to bes, or to commence a new or a decision to transfer or ent from the facility as specified	{F (000}	correction for purposes of regulatory The facility is submitting this plan of a comply with applicable law and not as a or statement of agreement with respect to deficiencies herein. To remain in compliance with all feder regulations, the center has taken or w actions set forth in this plan of correction of correction constitutes the center's a compliance such that all alleged defici- have been or will be corrected by the of indicated. This plan of correction constitutes our a compliance. F-157 The facility will inform the consult with the resident's p and if known, notify the r legal representative or an in family member when their change in the resident's mental, or psychosocial state may require physician interver Resident #5 was moved comparable room on the sa over the weekend because bell was not working. Althous member stated they were there was no documentation record. The facility policy was revier updated to include faxing a the update: Notice of Disci Transfer from this Facility surveyors were able to pro- with. Staff was reminded to d	compliance. correction to an admission of the alleged ral and state vill take the n. The plan ullegation of tencies cited late or dates llegations of resident; hysician; esident's nterested re is a physical, us which ntion. d to a ume unit, his call gh family notified n on the wed and copy of narge or form that povide us	11/14/08
		SUPPLIER REPRESENTATIVE'S SIGNATURE					(X6) DATE

LABORATORY	DIDECTODIC	$\Delta D D D \Delta V$	IDED/C	I IDDI		T A T N /E'C	CICNIATUDE	
LABURATURT	DIRECTURA	UR PROV	IDERIA	UPPL	EPRESEN	IALIVE S	SIGNATURE	

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

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

PRINTED: 11/06/2008 FORM APPROVED OMB NO: 0938-0391

<u> </u>	<u>KS FUR MEDIÇARE (</u>						0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			(X3) DATE SU COMPLET	FED
		095028	B. WIN	G			R 9/2008
NAME OF PF				STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
					050 MILITARY ROAD NW		
INGLESI	DE AT ROCK CREEK		ĺ		ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
{F 157}	Continued From pag	ge 1 T is not met as evidenced by:	{F 1	57}	has disposed of all the old and replaced them with th ones. Social Service will c to audit the faxing of notifica the Health Department.	e new ontinue	
{F 160} SS=D	Upon the death of a deposited with the fa within 30 days the re	EYANCE UPON DEATH resident with a personal fund acility, the facility must convey esident's funds and a final	H al fund convey nal		Any concerns or trend continue to be brought	to the vement	
	accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by:		F-1	160	Upon the death of a resident personal fund deposited w facility, the facility must within 30 days the resident's and a final accounting of funds, to the individual or p	ith the convey funds those	11/14/08
	28, 2008, it was dete to convey the person	e Trial Balance, dated October ermined that facility staff failed nal funds of three (3) of six (6) within 30 days of expiration.	er d		jurisdiction administering resident's estate. Resident #F1 account has appropriately closed and the dispersed to the correct entiti	been money	
		Resident Fund Management			Resident #F2 account has appropriately closed and the dispersed to the correct entiti	the money	
-	indicated that Reside 2008; and there was	ce " dated October 28, 2008 ent F1 expired on May 12, a balance of \$817.97 in nt 169 days after the resident			Resident #F3 account has appropriately closed and the dispersed to the correct entiti	money	
	2. A review of the " Service, Trial Balance indicated that Reside 2008; and there was	Resident Fund Management ce "dated October 28, 2008 ent F2 expired on August 29, s a balance of \$384.12 in nt 60 days after the resident			All resident fund accounts been audited to ensure comp A policy and procedure was p place to ensure that all mon dispersed within 30 days resident's death. Finance have been inserviced on this and procedure.	liance. but into es are of the staff	

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

If continuation sheet Page 2 of 21

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	13 FUR MEDICARE						<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUIL			(X3) DATE SURVEY COMPLETED		
		095028	B. WING				R 9/2008
NAME OF PF	ROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	-	
INGLESI	DE AT ROCK CREEK				050 MILITARY ROAD NW /ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS)	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
{F 160}	3. A review of the " Service, Trial Balan indicated that Resid 22, 2008; and there	ge 2 Resident Fund Management ce " dated October 28, 2008 ent F3 expired on September was a balance of \$21.81 in unt 36 days after the resident	{F 1	60}	Routine audits will be condu the controller or his/her desi ensure compliance. Any co or trends will continue to be to the monthly Quality Impro meetings for evaluation intervention.	gnee to oncerns orought vement	
{F 253} SS=D	 28, 2008 at 3:19 PM acknowledged that if and F3 account was after they expired. 483.15(h) (2) HOUS The facility must promaintenance service 	view was conducted on October 1 with Employee #5. He/she the money in Residents F1, F2, 5 not conveyed within 30 days EKEEPING/MAINTENANCE wide housekeeping and es necessary to maintain a d comfortable interior.	{F 2	53}	F-253 The facility will housekeeping and maint services necessary to mai sanitary, orderly, and com interior.	ntain a	10/30/08
	Based on observation tour, it was determine maintain a clean envectore excessive items in the Upper Level and no observations were in Employees #1 and 2 10:00 AM until 1:30 The findings include 1. The storage room with excessive items chair, a chair, a lample ater, and boxes of	r n near room 176 was observed s such as empty boxes, a wheel p, four (4) large empty boxes, a f incontinent pads. The door rened fully due to the excessive			Night lights were replaced repaired before surveyors facility for rooms #87, 176,18 195. The wall has been re and documentation showin work schedule has been p to the State. Maintenance will continue to routine rounds identifying a that needs repair. Maint created an audit schedule fr list and will conduct routine to ensure items are identifi repaired in a timely mano other staff will also identify that need repair and bring t the attention of maintenance they can be repaired as need	eft the i0, 186, epaired ng the rovided o make nything enance om the audits ed and r. All v items hem to so that	

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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CMS 11/11/08

PRINTED: 11/06/2008 FORM APPROVED

	SFOR MEDICARE	& MEDICAID SERVICES					<u>0. 0938-0391 </u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
						— _R	
		095028	B. WIN	····		10/	29/2008
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			1	3050 MILITARY ROAD NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	ТХ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 253}	on the Upper Level of boxes stored on the bulbs, and a half-fille floor. The Utility/ele- near room 079 was wire stored on the flo from the annual re-c August 11, 2008. 3. Night lights were n rooms: 87, 176, 180 rooms observed. The the annual re-certific 11, 2008.	cal closet identified as room 178 was observed with three (3) floor, nine (9) used florescent ed trash bag in the middle of the ctrical closet on the lower level observed with three (3) boxes of oor. This is a repeat deficiency ertification survey completed not functional in the following , 186, and 195 in five (5) of 24 is is a repeat deficiency from cation survey completed August	{F 2	253}	Any concerns or trends continue to be brought to monthly Quality Improv meetings for evaluation intervention.	o the	
F 281 SS=D	The services provide must meet professio This REQUIREMEN Based on observatio interview, it was dete medication passes the administer Fiber pow recommendation for The findings include: A physician's order s	sheet for September 2008, that dated, directed "Gemfiber	F	281	The services provided or array by the facility must professional standards of qual Resident #JH4 has finally agra take his fiber in 8 ounces of Physician was notified. He that resident has been takin fiber in 4oz. since 6/17/05 an had no adverse effects. Staff will be re-inserviced by 1 08 that fiber is to be given v oz. of liquid. If the resident able to drink their 8 ounce attending physician is to be n and a new order is to be obta Supporting documentation s also be provided by physician	meet lity. eed to liquid. stated ng his d has l1-14- with 8 is not is not s the otified ained.	11/10/08

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Event ID: OXJZ12

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Facility ID: PRESBYTERIAN

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QAN 11/11/08

PRINTED: 11/06/2008
FORM APPROVED
OMB NO 0028 0201

<u>CENTER</u>	<u>RS FOR MEDICARE (</u>	<u>& MEDICAID SERVICES</u>				<u>OMB NO</u>	<u>. 0938-0391</u>
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. 001			R		
		095028	B. WIN	G			9/2008
NAME OF PR				STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
					50 MILITARY ROAD NW		
INGLESI	DE AT ROCK CREEK			W	ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
F 281	Continued From page mouth every day for		F	281	to support orders written addre risk versus the benefit. management will do random	Nursing audits of	
	On October 28, 2008, at approximately 9:20 AM, during the medication pass Employee# 9 mixed one (1) teaspoonful of fiber powder in 4 ounces of liquid and administered it to Resident JH4.			J	staff during Med Pass to ide trends or concerns that intervention. Any concerns c will continue to be brought monthly Quality Improvement for evaluation and intervention.	t need or trends to the	
	"Give one (1) rounde liquid." Notice: "Tal ounces (a full glass)	ed on the container stated, ed teaspoonful in 8 ounces of ke this product with at least 8 of liquid. Taking the product id may cause choking"			for evaluation and intervention.		
	28, 2008 at approxin Employee# 9. He/sh powder was mixed in administered to Res	iew was conducted on October nately 12: 00 PM with ne acknowledged that the Fiber n 4 ounces of liquid and ident JH4. eviewed on October 28, 2008.					
{F 309} SS=D	Each resident must provide the necessa maintain the highest and psychosocial we	F CARE receive and the facility must ry care and services to attain or practicable physical, mental, ell-being, in accordance with the essment and plan of care.	{F 3	09}	The facility provides the necess and services to each resident or maintain the highest pro- physical, mental, and psychoso being, in accordance we comprehensive assessment and care.	to attain acticable ocial well ith the	11/14/08
					Resident # JH6 received her actonel on 10/30/08.	weekly	
	1. The facility staff fa medication passes f administer Actonel ta	T is not met as evidenced by: ailed in one (1) of eight (8) to follow physician orders to ablets on weekly, on			The nurse responsible for "X"in actonel was counseled and inservicing on transcripti medication orders and me administration.	provided on of	
	Wednesday to JH6. The findings include	:			Twenty four hour chart au continue to be done by night sh		

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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QAS 11/11/08

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU COMPLE	
		095028	B. WIN				R 9/2008
	ROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 50 MILITARY ROAD NW ASHINGTON, DC 20015	10/2	3/2008
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES [•] BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
{F 309}	Physicians order sig directed, " Actonel tablet by mouth **Ev upon awakening 30 full glass of water ar dose is given on We On October 29, 2000 during the medication administered Vitron tablet, Oyst shell Ca Multivitamin tablet a Resident JH6. On October 29, 2000 during the reconcilia resident's medication Administration Reco Actonel was not give An "X" was marked instead of a nurse's A face-to-face interv 29, 2008, at approxi Employee# 7. He/sI night shift thought th discontinued becaus yellow. Employee # highlighted in yellow aware of the medica	Ined September 11, 2008 35 mg tablet, Take on Wed - 1 very week** for osteoporosis minutes prior to breakfast with a nd sit upright 30 minutes after ed. " 8 at approximately 9:35AM, on pass Employee# 10 C tablet, Vitamin B Complex licium / Vitamin D tablet, nd Benicar 20mg tablet to 8, at approximately 10:00 AM, tion of the on orders with the Medication rd (MAR). It was revealed that en to the Resident that morning. on the MAR for October 29th	{F 3	09}	nurse. New orders will co be written on physician ord Nursing management will routine random audits of M. for completeness. Routin meetings will be held t residents with significant ch continue to evaluate and as appropriate. Any concerns or trends brought to the monthly Improvement meetings for e and intervention.	ler sheet. conduct AR/TAR's e clinical o review ange and intervene will be Quality	
{F 323} SS=D	The facility must ens	ITS AND SUPERVISION sure that the resident s as free of accident hazards as h resident receives adequate istance devices to	{F 3	23}	The facility will ensure resident environment is accident hazards as is poss each resident receives supervision and assistive de	free of sible; and adequate	10/28/08

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>OMB NC</u>	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SU COMPLE	
			B. WING				R
		095028				10/2	29/2008
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			í	050 MILITARY ROAD NW		
				W	ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
{F 323}	Continued From page	ge 6	{F 3	323}	to prevent accidents.		
	prevent accidents.	IT is not met as evidenced by:			Storage rooms were clean organized on October 28 surveyors left the facility. Tar been removed from this are appropriate area on 10/28/08.	before ks have	
	Based on observation tour, it was determine a hazard free environexcessive items stor room and failed to s	ons during the environmental need the facility failed to maintain nment as evidence by red in the Lower Level storage upervise three (3) of three (3) ver Level during the breakfast			Contractor's equipment was r 10/28/08. Director of Main has provided inservicing to cor on how to safely secur equipment. He will be respon make sure that when contract working in the building that the following facility policy and pro- for safety.	tenance htractors e their hsible to tors are hey are	
	environment as evid belonging to the con helium observed in a Level.	to maintain a hazard free lence by excessive items ltractors and two (2) tanks of a storage closet on the Lower cross from room 079 was			The heat sensor was repaired. Nursing will assign a traine member to be in the dinin during meal times to supervision and assistance.	ed staff	
	observed with excess contractor such as s and two (2) tanks of Therapy to blow up I unlocked and not ab to the excessive am Additionally, the hea	ssive items belonging to the several doors, saws, other tools helium used by Recreational balloons. The door was ble to be opened completely due ount of items in the room. It sensor, part of the fire alarm g from the ceiling and wires			Maintenance went on room ro make sure multi-plugs wer appropriately and not a ha residents. Any found to compliant were re Maintenance will continue to routine rounds to include kee environment hazard Housekeeping staff will also for hazards and remove any	e used zard to be non emoved. o make oing the free. ook out	
	These observations Employees #1 and 2	were made in the presence of 2 on October 28, 2008 from at PM who acknowledged the			during scheduled cleaning. Nursing re-educated staff that member must be present ir room during meal times. Char	a staff dining	

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Event ID: OXJZ12

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Facility ID: PRESBYTERIAN

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QNS N/11/08

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FORM /	APPROVED
OMB NO	0938-0391

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIP	LE CONSTRUCTION	(X3) DATE S	JRVEY		
				(X2) MULTIPLE CON A. BUILDING		·	COMPLE	
	095028	B. WIN	B. WING		R 10/29/2008			
			стр		10/	2000		
DE AT ROCK CREEK			w	ASHINGTON, DC 20015				
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	(X5) COMPLETION DATE		
Continued From pag	je 7	{F 3	323}	Nurses will monitor that	a staff			
		•						
the lower level unit, observed alone in th in his/her wheelchair chair alarms attache unsupervised from 9	Residents F4, F5 and F6 were e dining room eating breakfast rs; all of the wheel chairs had d. The residents were			monthly Quality impr	ovement			
A. Review of Reside quarterly Minimum I completed August 2 coded in Section B (memory problems an Functioning and Stru- supervision for eatin	Data Set (MDS) assessment 1, 2008. The resident was Memory) as having short -term and in Section G (Physical uctural Problems) as requiring g. The resident was coded in							
problem. According to the phy September 4, 2008,	vsician ' s orders signed the resident was using a							
B. A review of Resid completed Septemb G [Physical Functior	ent F5 's quarterly MDS er 8, 2008 revealed that Section and Structural Problems]							
Deficit - Minimum to Plan" dated June 16	Moderate Assistance Care , 2008 revealed, "12. Assist							
	(EACH DEFICIENCY MUST OR LSC IDE Continued From pag findings at the time of 2. Facility staff failed (3) residents during On October 29, 2000 the lower level unit, observed alone in th in his/her wheelchair chair alarms attached unsupervised from 9 staff. A. Review of Reside quarterly Minimum D completed August 2 coded in Section B (memory problems an Functioning and Stru- supervision for eatinn Section K1 (Oral Pro- problem. According to the phy September 4, 2008, Wonder guard and b B. A review of Reside completed Septembo G [Physical Function eating was coded as up help. According to the car Deficit - Minimum to Plan" dated June 16	ROVIDER OR SUPPLIER DE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 findings at the time of the observations. 2. Facility staff failed to adequately supervise three (3) residents during the breakfast meal. On October 29, 2008 at approximately 9:45 AM, on the lower level unit, Residents F4, F5 and F6 were observed alone in the dining room eating breakfast in his/her wheelchairs; all of the wheel chairs had chair alarms attached. The residents were unsupervised from 9:45 AM to 9:50 AM by facility staff. A. Review of Resident F4's record revealed a quarterly Minimum Data Set (MDS) assessment completed August 21, 2008. The resident was coded in Section B (Memory) as having short -term memory problems and in Section G (Physical Functioning and Structural Problems) as requiring supervision for eating. The resident was coded in Section K1 (Oral Problems) as having a chewing problem. According to the physician 's orders signed September 4, 2008, the resident was using a Wonder guard and bed/chair alarm daily for safety. B. A review of Resident F5 's quarterly MDS completed September 8, 2008 revealed that Section G [Physical Function and Structural Problems] eating was coded as independent in eating and set	USBUZS ROVIDER OR SUPPLIER DE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 findings at the time of the observations. 2. Facility staff failed to adequately supervise three (3) residents during the breakfast meal. On October 29, 2008 at approximately 9:45 AM, on the lower level unit, Residents F4, F5 and F6 were observed alone in the dining room eating breakfast in his/her wheelchairs; all of the wheel chairs had chair alarms attached. The residents were unsupervised from 9:45 AM to 9:50 AM by facility staff. A. Review of Resident F4's record revealed a quarterly Minimum Data Set (MDS) assessment completed August 21, 2008. The resident was coded in Section B (Memory) as having short -term memory problems and in Section G (Physical Functioning and Structural Problems) as requiring supervision for eating. The resident was coded in Section K1 (Oral Problems) as having a chewing problem. According to the physician 's orders signed September 4, 2008, the resident was using a Wonder guard and bed/chair alarm daily for safety. B. A review of Resident F5 's quarterly MDS completed September 8, 2008 revealed that Section G [Physical Function and Structural Problems] eating was coded as independent in eating and set up help. According to the care plan entitled, "Self Care Deficit - Minimum to Moderate Assistance Care Plan" dated June 16, 2008 revealed, "12. Assist	USSU25 ROVIDER OR SUPPLIER DE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 findings at the time of the observations. 2. Facility staff failed to adequately supervise three (3) residents during the breakfast meal. On October 29, 2008 at approximately 9:45 AM, on the lower level unit, Residents F4, F5 and F6 were observed alone in the dining room eating breakfast in his/her wheelchairs; all of the wheel chairs had chair alarms attached. The residents were unsupervised from 9:45 AM to 9:50 AM by facility staff. A. Review of Resident F4's record revealed a quarterly Minimum Data Set (MDS) assessment completed August 21, 2008. The resident was coded in Section B (Memory) as having short -term memory problems and in Section G (Physical Functioning and Structural Problems) as requiring supervision for eating. The resident was coded in Section K1 (Orai Problems) as having a chewing problem. According to the physician 's orders signed September 4, 2008, the resident was using a Wonder guard and bed/chair alarm daily for safety. B. A review of Resident F5's quarterly MDS completed September 8, 2008 revealed that Section G [Physical Function and Structural Problems] eating was coded as independent in eating and set up help. According to the care plan entitiled, "Self Care Deficit - Minimum to Mod	OBSUZE STREET ADDRESS, CITY, STATE, ZIP CODE 385 MILITARY ROAD NW WASHINGTON, DC 2015 DE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 (Indings at the time of the observations. (F 323) Nurses will monitor that member is present during m monitor the discover and the breakfast in his/Are wheelchairs; all of the wheel chairs had chair alarms attached. The residents were unsupervised from 9:45 AM to 9:50 AM by facility staff. A. Review of Resident F4's record revealed a quarterly Minimum Data Set (MDS) assessment completed August 21, 2008, the resident was coded in Section K1 (Oral Problems) as having a chewing problem. A.ccording to the physician 's orders signed September 4, 2008, the resident was using a Wonder guard and bed/chair alarm daily for safety. B. A review of Resident F5's quarterly MDS completed September 8, 2008 revealed that Section G [Physical Function and Structural Problems] eating was coded as independent in eating and set up help. According to the care plan entitled, "Self Care Deficit - Minimum to Moderate Assistance Care Plan' dated June 16, 2008 revealed ', "12. Assist	OBSUZE OBSUZE 10/2 ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW DE AT ROCK CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW (EACH DEFIDENCY WENT DE PERCENDED BY FILL REGULATORY OR LSC DENTIFYING INFORMATION) PREVX TAG PREVX PREVX PREVX CORRECTVE ADDRESS, CITY, STATE, ZIP CODE Continued From page 7 findings at the time of the observations. PREVX TAG PREVX PREVX PREVX CORRECTVE ADDRESS FLOW OF CORRECTION SUMMARY STATEMENT OF DEFICIENCY) Continued From page 7 findings at the time of the observations. (F 323) Nurses will monitor that a staff member is present during mealtime. Nursing management will make random rounds to make sure staff is present. On October 29, 2008 at approximately 9:45 AM, on the lower level unit, Residents F4, F5 and F6 were observed alone in the dining room eating breakfast in his/her wheelchairs; all of the wheel chairs had chair alams attached. The resident were unsupervised from 9:45 AM to 9:50 AM by facility staff. Any concerns will be brought to the monthy Quality improvement meetings for evaluation and intervention. A review of Resident F4's record revealed a quarterly Minimum Data Set (MDS) assessment completed August 21, 2008. The resident was coded in Section G (Physical Functioning and Structural Problems) as requiring supervision for eating. The resident was completed August 21, 2008. The resident was completed September 8, 2008 revealed that Section G (Physical Function and Structural Problems)		

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Facility ID: PRESBYTERIAN

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045 11/11/08

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

CENTER	<u>RS FOR MEDICARE</u>	<u>& MEDICAID SERVICES</u>			ON	<u>/IB NO. 0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
		095028	B. WIN	3		R 10/29/2008	
	ROVIDER OR SUPPLIER	<u> </u>		3050 MILITAR	S, CITY, STATE, ZIP CODE Y ROAD NW DN, DC 20015	10/23/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	(EACH (PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE CROS NCED TO THE APPROPRIATE DEFICIEN		
{F 323} {F 333} SS=D	C. A review of Resic quarterly MDS asse 25, 2008. The resid having short-term m G requiring supervis According to the "Fa approach/interventic not leave resident al The resident fell on and October 29, 200 right subcapital femo 2008. The resident and returned on Jun was initiated by the I 2008. As per the plan of co survey completed Au F323 "3. During m ensure staff is in the The observation of r unsupervised lacked followed the plan of dated August 11, 20 483.25(m) (2) MEDIO	lent F6's record revealed a ssment completed September ent was coded Section B as emory problems and in Section ion for eating. Ill Prevention Care Plan" under on was a hand written entry, "Do one in room in wheelchair." May 25, July 12, September 16, 8. The resident sustained a oral neck fracture on May 25, was hospitalized for the fracture e 5, 2008. A bed/chair alarm Falls Committee on June 9, prrection from the re-certification ugust 11, 2008 for CFR 483.25, eal times the charge nurse must dining room supervising" esidents in the dining room l evidence that the facility care and the plan of correction 08. CATION ERRORS ure that residents are free of	{F 3 {F 3	Residen medicati Nurse i providec and trea	ts will be free of any signific fon errors. dentified was counseled a training related to Medica atment Administration. Nurs r will continue to monitor	and tion sing	
	Based on observatio interview, it was dete medication passes, t	n, record review and staff ermined in one (1) of eight (8) hat the facility staff failed to ssium chloride] as per		staff me	r will continue to monitor mber during random Med Pa Managers review medica at the end of each month.	ISS.	

Event ID: OXJZ12 Facility ID: PRESBYTERIAN

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010 11/11/08

PRINTED: 11/06/2008 FORM APPROVED

PRINTED: 11/06/2008 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF	CORRECTION		A. BUILDING				R
		095028	B. WIN	G			9/2008
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP C O DE 050 MILITARY ROAD NW		
INGLESI					ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 333}			{F 3	33}	Pharmacist will continue to do r		
	physicians order for	Resident JH5.			audits on all residents. educator will continue to do r		
	The findings include	:			Medication/Treatment Passe compliance. They will conti	inue to	
		gned September 24, 2008 20 mEq po [by mouth] qd	{F 386}			will be fiber is quid. If	
{F 386} SS=D	during the morning r JH5, Employee # 8 a capsule of KCI to the A face-to-face interv approximately 12:15 He/she acknowledge 10mEq should have resident. The records were re 483.40(b) PHYSICIA The physician must r program of care, incl treatments, at each v of this section; write, at each visit; and sig exception of influenz polysaccharide vacc administered per physician	iew was conducted at PM with Employee # 8. ed that two capsules of KCI been administered to the viewed October 28. 2008. N VISITS review the resident's total uding medications and visit required by paragraph (c) sign, and date progress notes n and date all orders with the a and pneumococcal			 to be given with 8ounces of liquid. If the resident is not able to drink the 8 ounces the attending physician is to be notified and a new order is to be obtained. Supporting documentation should also be provided by the physician to support orders written. Nursing management will do random audits of staff during Med Pass to identify any trends or concerns that need intervention. Any trends or concerns will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention. 67 The physician will review the resident's total program of care, including Medications and Treatments, at each visit. Resident's physician signed all orders before surveyors left the building. Medical Director spoke with physician and reminded him of facility policy. Charts will continue to be routinely audited by 		11/10/08
{F 425} SS=D	483.60(a), (b) PHAR The facility must pro	vide routine and emergency s to its residents, or obtain them			Medical Records and nursing office ma identify but not limited to, physicia compliant with signing orders and residents per facility policy and pr They will continue to notify physicians a physician still remains non-compli Medical Director will speak with Continuing this practice will result i privileges at the facility. Any concerns or trends will continu brought to the monthly Quality Impr meetings for evaluation and intervention	an being visiting rocedure. and if the iant the in them. in losing the to be rovement	

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Facility ID: PRESBYTERIAN

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014 11/11/08

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						<u>J. 0938-0391</u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TED
	095028	B. WING			R 10/29/2008	
			STR	REET ADDRESS, CITY, STATE, ZIP CODE	-	
DE AT ROCK CREEK			3	050 MILITARY ROAD NW		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SHOULD B	E CROSS-	(X5) COMPLETION DATE
§483.75(h) of this pa unlicensed personne law permits, but only of a licensed nurse. A facility must provid (including procedure acquiring, receiving, of all drugs and biolo each resident. The facility must em licensed pharmacist all aspects of the pro- the facility. This REQUIREMEN Based on observation medication carts and determined that the initial four (4) of eigh dose bottles.	Art. The facility may permit el to administer drugs if State or under the general supervision de pharmaceutical services is that assure the accurate dispensing, and administering ogicals) to meet the needs of ploy or obtain the services of a who provides consultation on ovision of pharmacy services in T is not met as evidenced by: on of three (3) of five (5) d staff interview, it was facility staff failed to date and t (8) controlled substance multi-	{F 4	25]	emergency drugs and biologicals residents. The medications that were not were wasted and replaced b pharmacy with a new bottle facility paid for. The expired eye drops were wasted and replaced with a new paid for by the facility. The charge nurses will contin monitor their carts and the medi- refrigerator for expired medication medication that has not been da time it was opened. Both refrige were audited by Nursing Manage to make sure all expired medi- was wasted and all op medication was dated as to ti was opened. Nurses were pro- with a memo reminding them of facility policy. Nursing Manage will continue to do random aud make sure facility policy is follow Monthly the pharmacist will co- refrigerator/cart audits to a	dated y the that also bottle ue to cation n and ted to rators ement cation bened me it vvided of the ement lits to bowed. nduct	
that the medication s after 90 days". The Manufacturer's p 2ml/ml bottles, stipul after 90 days". On October 28, 2008	should "Discard opened bottle backage insert for Lorazepam ates "Discard opened bottles 8, between approximately 12:20			Charts will continue to be rou audited by Medical Records Nursing Office Manager to identi not limited to: physicians compliant with signing orders visiting residents per facility polic procedure. They will continue to physicians and if the physician	and fy but being and y and notify n still	
	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DE AT ROCK CREEK DE AT ROCK CREEK SUMMARY ST/ (EACH DEFICIENCY MUST OR LSC IDE Continued From pag §483.75(h) of this pa unlicensed personne law permits, but only of a licensed personne law permits, but only of a licensed nurse. A facility must provice (including procedure acquiring, receiving, of all drugs and biolo each resident. The facility must em licensed pharmacist all aspects of the pro- the facility. This REQUIREMEN Based on observation medication carts and determined that the fi initial four (4) of eigh dose bottles. The findings include: On the Morphine Sul that the medication s after 90 days". The Manufacturer's p 2ml/ml bottles, stipul after 90 days".	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028 ROVIDER OR SUPPLIER 095028 CONTRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 S483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general 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 of three (3) of five (5) medication carts and staff interview, it was determined that the facility staff failed to date and initial four (4) of eight (8) controlled substance multi- dose bottles. The findings include: On the Morphine Sulfate 20mg/ml container it states that the medication should "Discard opened bottle after 90 days". The Manufacturer's package insert for Lorazepam 2ml/ml bottles, stipulates "Discard opened bottles	OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) M A BUIL 095028 OVIDER OR SUPPLIER 0 DE AT ROCK CREEK ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 10 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (F 4 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. ID 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 of three (3) of five (5) medication carts and staff interview, it was determined that the facility staff failed to date and initial four (4) of eight (8) controlled substance multi- dose bottles. The findings include: On the Morphine Sulfate 20mg/ml container it states that the medication should "Discard opened bottle after 90 days". The Manufacturer's package insert for Lorazepam 2ml/ml bottles, stipulates "Discard opened bottles after 90 days". On October 28, 2008, between approximately 12:20	OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTII A. BUILDIN B. WING OP5028 095028 ROVIDER OR SUPPLIER STF DE AT ROCK CREEK STF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 10 \$483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (F 425) 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. In 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. In This REQUIREMENT is not met as evidenced by: Based on observation of three (3) of five (5) medication carts and staff interview, it was determined that the facility staff failed to date and initial four (4) of eight (8) controlled substance multi- dose bottles. The findings include: On the Morphine Sulfate 20mg/ml container it states that the medication should "Discard opened bottles after 90 days". The Manufacturer's package insert for Lorazepam 2m/ml bottles, stipulates "Discard opened bottles after 90 days".	perpendicutes connection (M) PROVDERSUPPLIERCULA IDENTIFICATION NUMBER (M) AUTIFLE CONSTRUCTION A BUILDING 095028 B. WING DEVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30500 MILTARY ROAD NW WASHINGTON, DC 20015 DE AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES Continued From page 10 (EACH CERCIENCY MUST BEFRACEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OR CORRECT: (EACH CERCIENCE WONT BEFRACEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 (EACH CERCIENCE) BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 425) The facility provides routine emergency drugs and biologicals to all censed parsonnel to administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of all censed paramacist who provides consultation on all aspects of the provision of pharmacy services in the facility. The charge nurses will contin monitor their carts and staff failed to date and initial four (1) dreight (8) controlled substance multi- dose bottles. The findings include: On the Morphine Sulfate 20mg/ml container it states that the medication should "Discard opened bottle after 90 days". Nurses were pro- walled by Medical Records Nursign Office Manager to idention to limited to: physicians compliant with signing orders' visiting residents per facility policy is followed by Medical Records Nursign Office Manager to idention to limited to: physicians compliant with signing orders' visiting residents per facility policy <td>progencescies connection (x1) PROVIDERSUPPLIERCUE Destrict Connection (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE Connection (x3) DATE Connection DOUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3950 MILITARY ROAD RW WASHINGTON, DC 20015 107 DE AT ROCK CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 3950 MILITARY ROAD RW WASHINGTON, DC 20015 107 Continued From page 10 \$483.75(h) of this part. The facility may permit unicensed presonnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (F 425) The facility provides routine and emergency drugs and biologicals to its residents. The facility must provide pharmaceutical services acquing, receiving, dispensing, and administering or all drugs and biologicals) to meet the needs of each resident. (F 425) The endications that were not dated were wasted and replaced by the pharmacy with a new bottle that facility must provide pharmaceutical services 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 the facility. The charge nurses will continue to monitor their carts and the medication refigerator for ex has not been dated to time it was opened. Both refigerators were audited by Nursing Management to make sure all expired medication refigerators and staft interview. It was determined that the facility staff failed to date and initial four (4) of eight (6) controlled substance multi- dose bottles. Charts will continue to be routinely audited by Nursing Management were audited by Nursing Managemen</td>	progencescies connection (x1) PROVIDERSUPPLIERCUE Destrict Connection (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE Connection (x3) DATE Connection DOUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3950 MILITARY ROAD RW WASHINGTON, DC 20015 107 DE AT ROCK CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 3950 MILITARY ROAD RW WASHINGTON, DC 20015 107 Continued From page 10 \$483.75(h) of this part. The facility may permit unicensed presonnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (F 425) The facility provides routine and emergency drugs and biologicals to its residents. The facility must provide pharmaceutical services acquing, receiving, dispensing, and administering or all drugs and biologicals) to meet the needs of each resident. (F 425) The endications that were not dated were wasted and replaced by the pharmacy with a new bottle that facility must provide pharmaceutical services 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 the facility. The charge nurses will continue to monitor their carts and the medication refigerator for ex has not been dated to time it was opened. Both refigerators were audited by Nursing Management to make sure all expired medication refigerators and staft interview. It was determined that the facility staff failed to date and initial four (4) of eight (6) controlled substance multi- dose bottles. Charts will continue to be routinely audited by Nursing Management were audited by Nursing Managemen

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Event ID: OXJZ12

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Facility ID: PRESBYTERIAN

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PRINTED: 11/06/2008 FORM APPROVED OMB NO 0938-0391

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	S FUR MEDICARE	& MEDICAID SERVICES				<u>). 0938-0391</u>	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095028	B. WING		R 10/29/2008		
NAME OF PF				STREET ADDRESS, CITY, STATE, ZIP CODE			
INGLESI	DE AT ROCK CREEK			3050 MILITARY ROAD NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	D BE CROSS-	(X5) COMPLETION DATE	
{F 431}	bottles were observe initials on the bottle. (3) Morphine Sulfate (1) Lorazepam 2m/n During a face-to-fac 9 and 14. They ackr above were not date the observations.	wing multi-dose medication ed opened; with no dates or e 20mg/ml, 30 ml bottle	{F 42 {F 42	Any concerns or trends will be brought to the mont Improvement meetings for and intervention.	y. continue to hly Quality evaluation		
SS=D	licensed pharmacist records of receipt ar drugs in sufficient de reconciliation; and d in order and that an is maintained and pe Drugs and biologica labeled in accordance professional principl accessory and cauti expiration date wher In accordance with S facility must store all compartments under and permit only auth access to the keys. The facility must pro permanently affixed controlled drugs lister	ploy or obtain the services of a who establishes a system of ad disposition of all-controlled etail to enable an accurate etermines that drug records are account of all controlled drugs eriodically reconciled. Is used in the facility must be ce with currently accepted es, and include the appropriate onary instructions, and the mapplicable. State and Federal laws, the drugs and biologicals in locked r proper temperature controls, iorized personnel to have vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and		biologicals in locked co under proper temperature of permit only authorized per have access to the keys. Nurse responsible for pu delivered meds was re-en	mpartments ontrols, and ersonnel to tting away ducated on nufacturer's refrigeration d by the s needed. continue to medication lication and en dated to s well as ired to be or. Both by nursing all expired all opened time it was they were	10/30/08	

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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UN 11/11/08

PRINTED:	11/06/2008
FORM /	APPROVED
OMB NO	0038-0301

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0						<u>D. 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC			(X3) DATE SU COMPLE	
		095028	B. WING			R	
				CTD		10/2	29/2008
	DE AT ROCK CREEK				EET ADDRESS, CITY, STATE, ZIP CODE 050 MILITARY ROAD NW		
				N	VASHINGTON, DC 20015		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 431}	Control Act of 1976 abuse, except when package drug distrib	ge 12 and other drugs subject to the facility uses single unit pution systems in which the nimal and a missing dose can	{F 431}		them of the facility policy. management will continue random audits to make sure policy is followed. Month pharmacist will conduct refrince cart audits to assure compliant policy.	Nursing to do facility nly the gerator/ ice with	
	Based on observation determined that the store two (2) of eight	T is not met as evidenced by: on and staff interview, it was facility staff failed to properly t (8) medications in accordance er's specifications and discard spired medication.			Any concerns or trends will c to be brought to the monthly Improvement meetings for eva and intervention.	Quality	
	The findings include	:					
	Lorazepam 2mg/ml	nufacturer's insert for bottle, stipulates "Store at cold erate 36 degrees to 46 degrees					
	2003-2004, stipulate	ric Drug Therapy Handbook, ed, " the vial of Xalatan should as after opening of vial"					
	AM, during the inspective (2) Lorazepam 2 stored at room temp ophthalmic drops, wi 8/30/2008, was also been discarded on C						
	A face-to-face intervitime with Employee	iew conducted at that same #8 and 14. They					

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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QNAS 11/11/08

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PRINTED:	11/06/2008			
FORM APPROVED				
OND NO. O	000 0004			

CENTER	RS FOR MEDICARE &	& MEDICAID SERVICES				<u>_ OMB NC</u>	<u>). 0938-0391</u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE				
							R			
		095028	B. WING			10/2	9/2008			
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE					
	DE AT ROCK CREEK			3	050 MILITARY ROAD NW					
				N	ASHINGTON, DC 20015	_				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE			
{F 431}	Continued From pag	je 13	{F 4	131}						
	acknowledged that t improperly and the >	he Lorazepam vials were store Kalatan was expired.								
{F 441}	483.65(a) INFECTIC	ON CONTROL	{F 4	441}	The facility must establis	h and				
SS=D		e facility must establish and maintain an infection ntrol program designed to provide a safe,			maintain an infection control p designed to provide a safe, s and comfortable environment	ol program e, sanitary, ent and to	11/18/08			
	prevent the develop	ment and transmission of n. The facility must establish an			help prevent the developme transmission of disease and in	fection.				
	infection control prog				Staff member followed facility and procedure. She and fello					
		s, and prevents infections in the			were educated on changes m					
		t procedures, such as isolation an individual resident; and			the contact isolation policy.					
		f incidents and corrective								
	actions related to inf				Infection control program was u to include that staff must cont					
					wear a gown while providing ca					
		T is not met as evidenced by:			contact isolation room even					
		-			resident is not in the room ar are making the bed with clean li	•				
		n, staff interview and record nine (9) sampled residents, it								
	was determined that	facility staff failed to maintain			Staff will continue to be inservi					
	isolation precautions	for Resident #8 who was in			the updated policy by 11/18/08.					
	contact isolation.				On routine rounds staff v	vill be				
	The findings include:	:			observed by nursing manager see if they are compliant wi	nent to ith this				
	right foot, ankle and October 28, 2008 at of the wound was ob drainage from the to as wide as the anter	observation to Resident #8's leg area was conducted on 10:00 AM. The outer dressing served with serosanguineous p of the foot to the mid-shin and ior leg. The inner 4 x 4 gauze ount of moist serosanguineous								policy. On the spot training provided if they find any areas compliance. Any concerns or will continue to be brought monthly Quality Improvement r for evaluation and intervention.
		bbserved making the bed on 1:05 PM in room 90 wearing personal protective								

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

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Facility ID: PRESBYTERIAN

If continuation sheet Page 14 of 21

QUAS 11/11/08

PRINTED:	11/06/2008
FORM /	APPROVED
	0038-0301

DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICADE	& MEDICAID	

NAME OF PROVIDER OR SUPPLIER INDLESIDE AT ROCK CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 300 MIUTARY ROAD WW WASHINGTON, DC 20015 MUME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 MIUTARY ROAD WW WASHINGTON, DC 20015 Output Colspan="2">OUTPUT RESCRETTION OF CONSCRETTION ORLSCIDENTFYING INFORMATION MUME OF PROVIDER AT ROCK CREEK ID PREFIX (EACH DEFICIENCY WITS ER PRECEDED STULL RESULATORY ORLSCIDENTFYING INFORMATION) ID PREFIX (F 441] PROVIDER ALL OF CONSC (CONSCRETTING ADDRESS (CONSCRETTING ADDRESS) OUPPL (CONSCRETTING ADDRESS) (F 441] Continued From page 14 equipment. Equipment and signage were present outside of the room to indicate that the resident was in isolation. (F 441) (F 441) (F 441) A face-to-face interview was conducted at the time of the observation with Employee #13. Heishe stated, "I now that this resident is in contact isolation. But (heishe) is not here and I already removed the solied linen. 1 am just making the bed." A face-to-face interview was conducted with Employee #15 on October 29, 2008 at 745 AM. Heishe stated, "I am responsible for cleaning room 90. I know that the resident is in isolation. The nurse told me all I have to do is wear glows when I clean the room. Everyday I Wipe down the befalls, the furniture and vacuum the carpet. Then I clean the bathroom. I don't clean the mattrass until the isolation is over. Yesterday (COLOBER 29, 2008). A review of Resident #8's record revealed that the resident measpinal, from October 10, 2008 with a diagnosis of MMENCHIN About wob cited leg wound. An a	STATEMENT	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE SOS MULTARY ROAD WW WASHINGTON, DC 20015 (MULTARY ROAD WW MASHINGTON, DC 20015 Street ADDRESS, CITY, STATE, ZP CODE SOS MULTARY ROAD WW WASHINGTON, DC 20015 (PRETX TAG (#ACH DEFICIENCY STREEMEDED SFULL REQULATORY ORLSC DEXTREMED BY FULL REQULATORY ORLSC DEXTREMED AND SFULL REQULATORY ORLSC DEXTREMED AND STATE MEEDED SHUL USING of the room to indicate that the resident was in isolation. Image: PROVIDER 97.40 (CORRECTIVE ADDRESS) (#E441) (F 441) Continued From page 14 equipment. Equipment and signage were present unisolation. (F 441) A face-to-face Interview was conducted at the time of the observation with Employee #13. He/she stated, " Know that this resident was in isolation. But [he/she] is not here and 1 already removed the solied linen. 1 am just making the bed." A face-to-face Interview was conducted with Employee #16 on October 29, 2008 at 745 AM. He/she stated, " an responsible for cleaning room 90. I know that the resident is in isolation. The nurse told me all have to do is wear gloves when I clean the room. Everyday I wipe down the bedrails, the furniture and vacuum the carpet. Then I clean the bathroom. I don't clean the mattress until the isolation is over. Yesterday (October 10, 2008 with a diagnosis of Methicine Resistant Staphylococcus Aureus (MRSA) in the above cled leg wound. An admission order dated October 10, 2008 with a diagnosis of Methicine Resistant Staphylococcus Aureus (MRSA) in the above cled leg wound. An admission order dated October 10, 2008 with a diagnosis of Methicine Resistant Staphylococcus Aureus (MRSA) in the above cled leg wound. An admission order dated October 10, 2008 directed, "Contact precautions for MRSA/wound." The resident received antibicic t			095028	B. WING					
Priezy TAG (EACH DEPICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTEYING INFORMATION) PREX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) Coming ON TAG (F 441) Continued From page 14 equipment. Equipment and signage were present outside of the room to indicate that the resident was in isolation. (F 441) (F 441) A face-to-face interview was conducted at the time of the observation with Employee #13. He/she stated, "I know that this resident is in contact isolation. But [he/she] is not here and I already removed the solied linen. I am just making the bed." (F 441) A face-to-face interview was conducted with Employee #16 on October 29, 2008 at 7.45 AM. He/she stated, "I am responsible for cleaning room 90. I know that the resident is in isolation. The nurse told me all have to do is waar gloves when I clean the room. Everyday I wipe down the bedrails, the furniture and vacuum the carpet. Then I clean the bathroom. I don't clean the mattress until the isolation is over. Yesterday (October 28, 2008) I cleaned the room after my lunch, about two o'clock." A review of Resident #8's record revealed that the resident was admitted to the facility on October 10, 2008 with a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA) in the above cited leg wound. An admission order dated October 10, 2008 directed, "Contact precautions for MRSA/wound." The resident received antibiotic therapy, continued from the hospital, from October 10 through October 14, twice daily. A follow-up wound culture was scheduled for October 29, 2008. According to the "Wound Documentation Form"					3	050 MILITARY ROAD NW	•		
 equipment. Equipment and signage were present outside of the room to indicate that the resident was in isolation. A face-to-face interview was conducted at the time of the observation with Employee #13. He/she stated, "I know that this resident is in contact isolation. But [he/she] is not here and I already removed the solited linen. I am just making the bed." A face-to-face interview was conducted with Employee #16 on October 29, 2008 at 7:45 AM. He/she stated, "I am responsible for cleaning room 90. I know that the resident is in isolation. The nurse told me all I have to do is wear gloves when I clean the room. Everyday I wijne down the bedrails, the furniture and vacuum the carpet. Then I clean the toom. Everyday I wijne down the bedrails, the furniture and vacuum the carpet. Then I clean the toom. Everyday I wijne down the bedrails, the furniture and vacuum the carpet. Then I clean the room after my lunch, about two o'clock." A review of Resident #8's record revealed that the resident was admitted to the facility on October 10, 2008 with a diagnosis of MRSA) in the above cited leg wound. An admission order dated October 10, 2008 directed, "Contact precautions for MRSA/wound." The resident received antibiotic therapy, continued from the hospital, from October 10, 2008. According to the "Wound Documentation Form" 	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD BE	E CROSS-	COMPLÉTION	
	{F 441}	equipment. Equipm outside of the room t in isolation. A face-to-face interv of the observation w stated, "I know that t isolation. But [he/she removed the soiled I bed." A face-to-face interv Employee #16 on Oc He/she stated, "I am 90. I know that the r nurse told me all I ha clean the room. Eve the furniture and vac the bathroom. I don isolation is over. Ye cleaned the room aff A review of Resident resident was admitte 2008 with a diagnosi Staphylococcus Auro leg wound. An admi 2008 directed, "Contact precautions The resident receive from the hospital, fro 14, twice daily. A fol scheduled for Octobe According to the "Wo	ent and signage were present to indicate that the resident was was conducted at the time ith Employee #13. He/she his resident is in contact a) is not here and I already inen. I am just making the was conducted with ctober 29, 2008 at 7:45 AM. responsible for cleaning room esident is in isolation. The type to do is wear gloves when I ryday I wipe down the bedrails, uum the carpet. Then I clean t clean the mattress until the sterday (October 28, 2008) I er my lunch, about two o'clock." #8's record revealed that the d to the facility on October 10, s of Methicillin Resistant eus (MRSA) in the above cited ssion order dated October 10, for MRSA/wound." ed antibiotic therapy, continued m October 10 through October low-up wound culture was er 29, 2008.	{F 4	41}				

Facility ID: PRESBYTERIAN

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PRINTED: 11/06/2008 FORM APPROVED OMB NO 0938-0391

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:		A. BUILDING			TED	
						- R		
		095028	D. WIN			10/2	29/2008	
NAME OF PROVIDER OR SUPPLIER				3	REET ADDRESS, CITY, STATE, ZIP CODE 8050 MILITARY ROAD NW NASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETION DATE	
{F 441}	Continued From pag	ge 15	{F 4	41}				
		ber 10 through October 27, ge amount of serosanguineous						
	October 20, 2008, de "Contact Precaution	s." However there was no tion that explained when to use						
	"Guideline for Isolati Transmission of Infe Settings 2007," on p PrecautionsHealth patients on Contact gloves for all interact	nter of Disease Control, on Precautions: Preventing octious Agents in Healthcare bage 70 under "III.B.1 Contact incare personnel caring for Precautions wear a gown and tions that may involve contact otentially contaminated areas in ment."						
	Precautions" with an under "Policy - Conta addition to Standard resident who is color epidemiologically im can be transmitted b	ility's policy, "Contact effective date of May 15, 2007, act Precautions will be used in Precautions when caring for a nized or infected with portant microorganisms that y direct contact (hand or skin to act with environmental surfaces ronment."						
	contact with resident	Use barrier precautions for all t and resident's immediate ear gown if potential contact rial"						
		maintain isolation precautions was in contact isolation. The October 29, 2008.						

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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ОЩА И/11/08

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES				-	0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095028	B. WIN	IG		í .	R 9/2008
NAME OF PR		L		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
INGLESI					050 MILITARY ROAD NW /ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 492} SS=D			{F 4	192}	The facility must operate and services in compliance w applicable Federal State and laws, regulations, and codes, a accepted professional standar principles that apply to profes providing services in such a fac Resident #5 was moved	ith all I Local nd with ds and sionals ility.	11/14/08
					comparable room on the sam over the weekend because h bell was not working. Although stated they were notified there documentation on the record. Nurse was re-educated that all she was with a licensed pha from the survey team she must nurse from the facility with wasted medication.	same unit, e his call ugh family ere was no d. t although bharmacist ust have a	
	Resident #5 who wa within the facility. A review of Resident physician's telephon that documented, "T room]" A social worker's not	to follow state regulations for s relocated to another room t #5's record revealed a e order dated October 25, 2008 ransfer resident from [room] to te dated October 27, 2008, ent transferred to [room] for			Facility policy was reviewed updated to include faxing a co- the updated "Notice of Discha Transfer from this Facility or rela- within this Facility" form the surveyors were able to prov- with. Staff was reminded to do the notification of appr individuals. Social Service disposed of all the old form replaced them with the new Social Service will continue to the fazing of notification to the	copy of arge or ocation at the ide us cument opriate s has ns and ones. o audit	
	administrative purpo to the transfer Phy There was no evider complied with 44DCl	sesResponsible party agrees sician notified" nce in the record that the facility			Department. Any concerns will continue	to be Quality	

Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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PRINTED: 11/06/2008

0415 11/11/08

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES): 11/06/2008 / APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII			(X3) DATE SURVEY COMPLETED	
		095028	B. WIN	IG _			R 9/2008
NAME OF PF				ST	TREET ADDRESS, CITY, STATE, ZIP CODE	L10/2	0/2000
INGLESI	DE AT ROCK CREEK				3050 MILITARY ROAD NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETION DATE
{F 492}	Continued From pag	ge 17	{F 4	192	2}		
	transferred or relocal shall give that reside both oral and written procedures for conte date of the discharge oral and written notic calendar days before the facility(d) writ minimum contain: (1 in detail and not in c proposed discharge, proposed effective d or relocation; (3) a s have a right to challed discharge, transfer, per the language of request form; (5) nar number of person ch supervising the disch the names, addresse the Long-Term Omb legal services organi written notice require placed in the resider transmitted to the Ma the Department of H Term Care Ombudsr A face-to-face intervi 28, 2008 at 1:00 PM #12, who acknowled including the above of	sident is to be discharged, ited, a facility representative ent and his or her representative a notice of the reasons for, esting, and proposed effective e, transfer, or relocationthe ce shall be givenat least 7 e a proposed relocation within ten notice requiredshall at) The specific reason(s) stated onclusory language for the , transfer or relocation; (2) ate of the discharge, transfer, tatement that includes 'You enge this facility's decision to or relocate you(continued as the regulation); (4) hearing me, address and telephone harged with the responsibility of harge, transfer or relocation; (6) es and telephone numbers of udsman program and local izations. (e) copies of the edof this section shall be ayor's designeeDirector of uman Services and the Long- man"					

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Facility ID: PRESBYTERIAN

If continuation sheet Page 18 of 21

QNS 11/11/08

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 11/06/2008 APPROVED . 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI			(X3) DATE SURVEY COMPLETED	
		095028	B. WIN	IG			R 9/2008
NAME OF PF			•		REET ADDRESS, CITY, STATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK				050 MILITARY ROAD NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	E CROSS-	(X5) COMPLETION DATE
{F 492}	Continued From page	ge 18	{F 4	92}			
	witness the wasting	iled to have a licensed nurse of a controlled substance one (1) of eight (8) medication		-			
	The findings include	:					
	controlled meds are nurses employed by	n " stipulates, "Wasted destroyed by two licensed the facility, and the disposal is accountability record on the line					
	during the medicatio Methylphenidate 5m the medication cart. tablet and discarded located on the side of	B, at approximately 9:20 AM in pass, a tablet of g for Resident JH4 dropped on Employee # 9 picked up the it in the trash receptacle of the medication cart. There ed nurse to witness the disposal					
	28, 2008 at approxin #9. He/she acknowl	iew was conducted on October nately 12:15 PM with Employee edged that another licensed ssed the wasting of the tablet.					
F 514 SS=D	483.75(I) (1) CLINIC	AL RECORDS	F	514	The facility must maintain	clinical	
	resident in accordan standards and practi	intain clinical records on each ce with accepted professional ices that are complete; ted; readily accessible; and ized.			records on each resident in acc with accepted professional st and practices that are co accurately documented;	ordance	10/29/08
	information to identif	nust contain sufficient y the resident; a record of the nts; the plan of care and					

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Event ID: OXJZ12

Facility ID: PRESBYTERIAN

If continuation sheet Page 19 of 21

Q4A 11/11/08

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 11/06/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY TED
	095028		B. WIN	IG		10/:	R 29/2008
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 8050 MILITARY ROAD NW VASHINGTON, DC 20015	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	ILL. IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 514	services provided; th screening conducted notes. This REQUIREMEN Based on record rev determined that the the administration of October 2008 Medic (MAR) for Resident of The findings include On October 29, 2008 review of Resident of physician 's order da directed, "Percocet mouth] q4hrs [every" The October 2008 M with signatures that October 2,3,4,5,6,7,8 evidence by initials of the dates mentioned The "Controlled Me indicated the Percoc controlled substance the following dates C 1,2,3,4,5,6,7,8,9,10, There was no evider	T is not met as evidenced by: iew and staff interview, it was facility staff failed to document controlled substance on the ation Administration Record JH1. 3, at approximately 11:00 AM, a s JH1 record revealed a ated September 28, 2008 that 5/325mg one (1) tab po [by 4 hours] prn [as needed] - pain AR was reviewed and indicated Percocet was administered on 3,9,10,11,12,17and 24 as entered in the allotted areas for dication Utilization Record " et was removed from the cabinet and administered on 0,0tober 11,12,13,14,15,17 and 24 2008. ice indicated on the October poet was administered on	F	514	Staff member who failed to de Percocet was counseled and p with policy and procedure cou- medication Administration. Nurse Managers review me regime at the end of each Pharmacist will continue to do audits on all residents. educator will continue to do Medication / Treatment Pass compliance. They will cont provide nursing with re-educ determined to need it. Nursing Management will do audits of staff during Med I identify and trends or concer- need intervention. Any concerns or trends will of to be brought to the monthly Improvement meetings for ev- and intervention.	provided ncerning edication month. monthly Nurse random eses for tinue to cation if random Pass to rns that continue Quality	

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Facility ID: PRESBYTERIAN

If continuation sheet Page 20 of 21

QAS 11/11/08

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 11/06/2008 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI			(X3) DATE SURVEY COMPLETED		
		095028	B. WIN	NG _			R 9/2008
l	ROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	١X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 514	A face-to-face interv 29, 2008 at approxin #15. He/she acknow indicate with signatu substance was adm	ge 20 view was conducted on October mately 11:00 AM with Employee wledged that the MAR did not ures that the controlled inistered to Resident JH1. ewed on October 29, 2008.	F	51			

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

Event ID: OXJZ12

Facility ID: PRESBYTERIAN

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QIPS 11/11/08