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 10/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	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 000}	INITIAL COMMENTS On October 28-29, 2008 a follow-up survey was conducted to the annual re-certification survey that was concluded on August 11, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. On October 28-29, 2008 a follow-up survey was	{F 000}	Ingleside at Rock Creek is filling this plan of correction for purposes of regulatory compliance. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. This plan of correction constitutes our allegations of compliance. F-157 The facility will inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a change in the resident's physical, mental, or psychosocial status which may require physician intervention. Resident #5 was moved to a comparable room on the same unit, over the weekend because his call bell was not working. Although family member stated they were notified there was no documentation on the record. The facility policy was reviewed and updated to include faxing a copy of the update: Notice of Discharge or Transfer from this Facility or Relocation within this Facility form that surveyors were able to provide us with. Staff was reminded to document the notification of appropriate individuals. Social Services	11/14/08
{F 157} SS=D	483.10(b) (11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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

Dr R. Schiff, Administrator 11/11/08

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

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{F 157}	Continued From page 1 This REQUIREMENT is not met as evidenced by: {F 160} 483.10(c) (6) CONVEYANCE UPON DEATH SS=D Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on a review of the Resident Fund Management Service Trial Balance, dated October 28, 2008, it was determined that facility staff failed to convey the personal funds of three (3) of six (6) deceased residents within 30 days of expiration. Residents F1, F2, and F3. The findings include: 1. A review of the " Resident Fund Management Service, Trial Balance " dated October 28, 2008 indicated that Resident F1 expired on May 12, 2008; and there was a balance of $817.97 in Resident F1's account 169 days after the resident expired. 2. A review of the " Resident Fund Management Service, Trial Balance " dated October 28, 2008 indicated that Resident F2 expired on August 29, 2008; and there was a balance of $384.12 in Resident F2's account 60 days after the resident expired.	{F 157}	has disposed of all the old forms and replaced them with the new ones. Social Service will continue to audit the faxing of notification to the Health Department. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention. F-160 Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Resident #F1 account has been appropriately closed and the money dispersed to the correct entities. Resident #F2 account has been appropriately closed and the money dispersed to the correct entities. Resident #F3 account has been appropriately closed and the money dispersed to the correct entities. All resident fund accounts have been audited to ensure compliance. A policy and procedure was put into place to ensure that all monies are dispersed within 30 days of the resident's death. Finance staff have been inserviced on this policy and procedure.	11/14/08

ARS 11/11/08

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{F 160}	Continued From page 2 3. A review of the " Resident Fund Management Service, Trial Balance " dated October 28, 2008 indicated that Resident F3 expired on September 22, 2008; and there was a balance of $21.81 in Resident F3's account 36 days after the resident expired. A face-to-face interview was conducted on October 28, 2008 at 3:19 PM with Employee #5. He/she acknowledged that the money in Residents F1, F2, and F3 account was not conveyed within 30 days after they expired.	{F 160}	Routine audits will be conducted by the controller or his/her designee to ensure compliance. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	
{F 253} SS=D	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain a clean environment as evidence by excessive items in two (2) storage closets on the Upper Level and non-functioning night lights. These observations were made in the presence of Employees #1 and 2 on October 28, 2008 from 10:00 AM until 1:30 PM. The findings include: 1. The storage room near room 176 was observed with excessive items such as empty boxes, a wheel chair, a chair, a lamp, four (4) large empty boxes, a heater, and boxes of incontinent pads. The door was unable to be opened fully due to the excessive amount of items stored in the room.	{F 253}	F-253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Night lights were replaced and /or repaired before surveyors left the facility for rooms #87, 176,180, 186, 195. The wall has been repaired and documentation showing the work schedule has been provided to the State. Maintenance will continue to make routine rounds identifying anything that needs repair. Maintenance created an audit schedule from the list and will conduct routine audits to ensure items are identified and repaired in a timely manor. All other staff will also identify items that need repair and bring them to the attention of maintenance so that they can be repaired as needed.	10/30/08

11/11/08

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{F 253}	Continued From page 3 2. The Utility/electrical closet identified as room 178 on the Upper Level was observed with three (3) boxes stored on the floor, nine (9) used florescent bulbs, and a half-filled trash bag in the middle of the floor. The Utility/electrical closet on the lower level near room 079 was observed with three (3) boxes of wire stored on the floor. This is a repeat deficiency from the annual re-certification survey completed August 11, 2008. 3. Night lights were not functional in the following rooms: 87, 176, 180, 186, and 195 in five (5) of 24 rooms observed. This is a repeat deficiency from the annual re-certification survey completed August 11, 2008. Employees #1 and 2 acknowledged the findings at the time of the observations.	{F 253}	Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	
F 281 SS=D	483.20(k) (3) (i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined in one (1) of eight (8) medication passes that the facility staff failed to administer Fiber powder per manufacturer recommendation for Resident JH4. The findings include: A physician's order sheet for September 2008, that was signed, but not dated, directed "Gemfiber Powder, 1 teaspoonful in liquid by	F 281	The services provided or arranged by the facility must meet professional standards of quality. Resident #JH4 has finally agreed to take his fiber in 8 ounces of liquid. Physician was notified. He stated that resident has been taking his fiber in 4oz. since 6/17/05 and has had no adverse effects. Staff will be re-inserviced by 11-14-08 that fiber is to be given with 8 oz. of liquid. If the resident is not able to drink their 8 ounces the attending physician is to be notified and a new order is to be obtained. Supporting documentation should also be provided by physician	11/10/08

11/11/08

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F 281	Continued From page 4 mouth every day for constipation. " 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. The directions located on the container stated, "Give one (1) rounded teaspoonful in 8 ounces of liquid." Notice: "Take this product with at least 8 ounces (a full glass) of liquid. Taking the product with out enough liquid may cause choking" A face-to-face interview was conducted on October 28, 2008 at approximately 12: 00 PM with Employee# 9. He/she acknowledged that the Fiber powder was mixed in 4 ounces of liquid and administered to Resident JH4. The recorded was reviewed on October 28, 2008.	F 281	to support orders written addressing the risk versus the benefit. Nursing management will do random audits of staff during Med Pass to identify any trends or concerns that need intervention. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	
{F 309} SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. The facility staff failed in one (1) of eight (8) medication passes to follow physician orders to administer Actonel tablets on weekly, on Wednesday to JH6. The findings include:	{F 309}	The facility provides the necessary care and services to each resident to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. Resident # JH6 received her weekly actonel on 10/30/08. The nurse responsible for "X"ing out the actonel was counseled and provided inservicing on transcription of medication orders and medication administration. Twenty four hour chart audits will continue to be done by night shift	11/14/08

QRS 11/11/08

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{F 309}	Continued From page 5 Physicians order signed September 11, 2008 directed, " Actonel 35 mg tablet, Take on Wed - 1 tablet by mouth **Every week** for osteoporosis upon awakening 30 minutes prior to breakfast with a full glass of water and sit upright 30 minutes after dose is given on Wed. " On October 29, 2008 at approximately 9:35AM, during the medication pass Employee# 10 administered Vitron C tablet, Vitamin B Complex tablet, Oyst shell Calcium / Vitamin D tablet, Multivitamin tablet and Benicar 20mg tablet to Resident JH6. On October 29, 2008, at approximately 10:00 AM, during the reconciliation of the resident's medication orders with the Medication Administration Record (MAR). It was revealed that Actonel was not given to the Resident that morning. An "X" was marked on the MAR for October 29th instead of a nurse's initials. A face-to-face interview was conducted on October 29, 2008, at approximately 10:20 AM with Employee# 7. He/she stated that the nurse on the night shift thought that the medication was discontinued because the order was highlighted in yellow. Employee #7 explained that the order was highlighted in yellow to make the medication nurse aware of the medication's administration time. The record was reviewed on October 29, 2008.	{F 309}	nurse. New orders will continue to be written on physician order sheet. Nursing management will conduct routine random audits of MAR/TAR's for completeness. Routine clinical meetings will be held to review residents with significant change and continue to evaluate and intervene as appropriate. Any concerns or trends will be brought to the monthly Quality Improvement meetings for evaluation and intervention.	
{F 323} SS=D	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	{F 323}	The facility will ensure that the resident environment is free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices	10/28/08

11/11/08

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{F 323}	Continued From page 6 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined the facility failed to maintain a hazard free environment as evidence by excessive items stored in the Lower Level storage room and failed to supervise three (3) of three (3) residents on the Lower Level during the breakfast meal. The findings include: 1. The facility failed to maintain a hazard free environment as evidence by excessive items belonging to the contractors and two (2) tanks of helium observed in a storage closet on the Lower Level. The storage room across from room 079 was observed with excessive items belonging to the contractor such as several doors, saws, other tools and two (2) tanks of helium used by Recreational Therapy to blow up balloons. The door was unlocked and not able to be opened completely due to the excessive amount of items in the room. Additionally, the heat sensor, part of the fire alarm system, was hanging from the ceiling and wires were exposed. These observations were made in the presence of Employees #1 and 2 on October 28, 2008 from at approximately 1:00 PM who acknowledged the	{F 323}	to prevent accidents. Storage rooms were cleaned and organized on October 28 before surveyors left the facility. Tanks have been removed from this area to an appropriate area on 10/28/08. Contractor's equipment was removed 10/28/08. Director of Maintenance has provided inservicing to contractors on how to safely secure their equipment. He will be responsible to make sure that when contractors are working in the building that they are following facility policy and procedures for safety. The heat sensor was repaired. Nursing will assign a trained staff member to be in the dining room during meal times to provide supervision and assistance. Maintenance went on room rounds to make sure multi-plugs were used appropriately and not a hazard to residents. Any found to be non compliant were removed. Maintenance will continue to make routine rounds to include keeping the environment hazard free. Housekeeping staff will also look out for hazards and remove any if found, during scheduled cleaning. Nursing re-educated staff that a staff member must be present in dining room during meal times. Charge	

AMS 11/11/08

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{F 323}	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 with set-up of meals PRN ..."	{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. Any concerns will be brought to the monthly Quality improvement meetings for evaluation and intervention.	

OMS
11/11/08

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{F 323}	Continued From page 8 C. A review of Resident F6's record revealed a quarterly MDS assessment completed September 25, 2008. The resident was coded Section B as having short-term memory problems and in Section G requiring supervision for eating. According to the "Fall Prevention Care Plan" under approach/intervention was a hand written entry, "Do not leave resident alone in room in wheelchair." The resident fell on May 25, July 12, September 16, and October 29, 2008. The resident sustained a right subcapital femoral neck fracture on May 25, 2008. The resident was hospitalized for the fracture and returned on June 5, 2008. A bed/chair alarm was initiated by the Falls Committee on June 9, 2008. As per the plan of correction from the re-certification survey completed August 11, 2008 for CFR 483.25, F323 "...3. During meal times the charge nurse must ensure staff is in the dining room supervising ..." The observation of residents in the dining room unsupervised lacked evidence that the facility followed the plan of care and the plan of correction dated August 11, 2008.	{F 323}		
{F 333} SS=D	483.25(m) (2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined in one (1) of eight (8) medication passes, that the facility staff failed to administer KCl [Potassium chloride] as per	{F 333}	Residents will be free of any significant medication errors. Nurse identified was counseled and provided training related to Medication and treatment Administration. Nursing educator will continue to monitor this staff member during random Med Pass. Nurse Managers review medication regime at the end of each month.	11/14/08

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11/11/08

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{F 333}	Continued From page 9 physicians order for Resident JH5. The findings include: Physician's order signed September 24, 2008 directed, " Start KCl 20 mEq po [by mouth] qd [every day]. On October 28, 2008, at approximately 9:20 AM, during the morning medication pass for Resident JH5, Employee # 8 administered one (1) 10 mEq capsule of KCl to the resident. A face-to-face interview was conducted at approximately 12:15 PM with Employee # 8. He/she acknowledged that two capsules of KCl 10mEq should have been administered to the resident. The records were reviewed October 28. 2008.	{F 333}	Pharmacist will continue to do monthly audits on all residents. Nurse educator will continue to do random Medication/Treatment Passes for compliance. They will continue to provide nursing with re-education if determined to need it. Staff will be re-inserviced by 11/14/08 that fiber is 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.	
{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:	{F 386}	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 Medical Records and nursing office manager to identify but not limited to, physician being compliant with signing orders and visiting residents per facility policy and procedure. They will continue to notify physicians and if the physician still remains non-compliant the Medical Director will speak with them. Continuing this practice will result in losing privileges at the facility. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	11/10/08
{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			

ORS
11/11/08

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{F 425}	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. 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 after 90 days". On October 28, 2008, between approximately 12:20 and 2:40 PM, medication carts were	{F 425}	The facility provides routine and emergency drugs and biologicals to its residents. The medications that were not dated were wasted and replaced by the pharmacy with a new bottle that facility paid for. The expired eye drops were also wasted and replaced with a new bottle paid for by the facility. The charge nurses will continue to monitor their carts and the medication refrigerator for expired medication and medication that has not been dated to time it was opened. Both refrigerators were audited by Nursing Management to make sure all expired medication was wasted and all opened medication was dated as to time it was opened. Nurses were provided with a memo reminding them of the facility policy. Nursing Management will continue to do random audits to make sure facility policy is followed. Monthly the pharmacist will conduct refrigerator/cart audits to assure compliance with policy. Charts will continue to be routinely audited by Medical Records and Nursing Office Manager to identify but not limited to: physicians being compliant with signing orders and visiting residents per facility policy and procedure. They will continue to notify physicians and if the physician still remains non-compliant the Medical	10/29/08

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{F 425}	Continued From page 11 inspected. The following multi-dose medication bottles were observed opened; with no dates or initials on the bottle. (3) Morphine Sulfate 20mg/ml, 30 ml bottle (1) Lorazepam 2m/ml, 30 ml During a face-to-face interview with Employees# 8, 9 and 14. They acknowledged that the bottles listed above were not dated and/or initiated at the time of the observations.	{F 425}	Director will speak with them. Continuing this practice will result in losing privileges at the facility. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	
{F 431} SS=D	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 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	{F 431}	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. Nurse responsible for putting away delivered meds was re-educated on following manufacturer's recommendation regarding refrigeration of certain meds. Meds are clearly labeled by the pharmacy that refrigeration is needed. The charge nurses will continue to monitor their carts and the medication refrigerator for expired medication and medication that has not been dated to time it was opened, as well as medications that are required to be stored in the refrigerator. Both refrigerators were audited by nursing management to make sure all expired medication was wasted and all opened medication was dated as to time it was opened and finally that they were stored in the appropriate place. Nurses	10/30/08

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{F 431}	Continued From page 12 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 the facility staff failed to properly store two (2) of eight (8) medications in accordance with the manufacturer's specifications and discard one (1) of one (1) expired medication. The findings include: According to the Manufacturer's insert for Lorazepam 2mg/ml bottle, stipulates "Store at cold temperature - Refrigerate 36 degrees to 46 degrees Fahrenheit." The Facility's Geriatric Drug Therapy Handbook, 2003-2004, stipulated, "... the vial of Xalatan should be discarded 6 weeks after opening of vial ..." On October August 6, 2008, at approximately 9:45 AM, during the inspection of the medication cart, two (2) Lorazepam 2mg/ml, 30 ml bottles were stored at room temperature. An open vial of Xalatan ophthalmic drops, with an opening date of 8/30/2008, was also found. It [Xalatan] should have been discarded on October 15, 2008. A face-to-face interview conducted at that same time with Employee #8 and 14. They	{F 431}	were provided with a memo reminding them of the facility policy. Nursing management will continue to do random audits to make sure facility policy is followed. Monthly the pharmacist will conduct refrigerator/ cart audits to assure compliance with policy. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	

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{F 431}	Continued From page 13 acknowledged that the Lorazepam vials were store improperly and the Xalatan was expired.	{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: Based on observation, staff interview and record review for one (1) of nine (9) sampled residents, it was determined that facility staff failed to maintain isolation precautions for Resident #8 who was in contact isolation. The findings include: A wound treatment observation to Resident #8's right foot, ankle and leg area was conducted on October 28, 2008 at 10:00 AM. The outer dressing of the wound was observed with serosanguineous drainage from the top of the foot to the mid-shin and as wide as the anterior leg. The inner 4 x 4 gauze pads had a large amount of moist serosanguineous drainage. Employee #13 was observed making the bed on October 28, 2008 at 1:05 PM in room 90 wearing gloves and no other personal protective	{F 441}	The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Staff member followed facility policy and procedure. She and fellow staff were educated on changes made to the contact isolation policy. Infection control program was updated to include that staff must continue to wear a gown while providing care in a contact isolation room even if the resident is not in the room and they are making the bed with clean linen. Staff will continue to be inserviced on the updated policy by 11/18/08. On routine rounds staff will be observed by nursing management to see if they are compliant with this policy. On the spot training will be provided if they find any areas of non compliance. Any concerns or trends will continue to be brought to the monthly Quality Improvement meeting for evaluation and intervention.	11/18/08

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{F 441}	Continued From page 14	{F 441}		

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 soiled 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 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" initiated on October 10, 2008, the wound was

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{F 441}	Continued From page 15 described from October 10 through October 27, 2008 as having a large amount of serosanguineous drainage. A care plan entitled, "Infection Care Plan" initiated October 20, 2008, documented "Contact Precautions." However there was no approach or intervention that explained when to use the personal protective equipment. According to the Center of Disease Control, "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007," on page 70 under "III.B.1 Contact Precautions ...Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment." According to the facility's policy, "Contact Precautions" with an effective date of May 15, 2007, under "Policy - Contact Precautions will be used in addition to Standard Precautions when caring for a resident who is colonized or infected with epidemiologically important microorganisms that can be transmitted by direct contact (hand or skin to skin) or indirect contact with environmental surfaces in resident care environment." Under "Process - 4. Use barrier precautions for all contact with resident and resident's immediate environment. 4.2 Wear gown if potential contact with infectious material ..." Facility staff failed to maintain isolation precautions for Resident #8 who was in contact isolation. The record was reviewed October 29, 2008.	{F 441}		

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{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 record review for one (1) of nine (9) sampled residents, it was determined that facility staff failed to follow state regulations: for one (1) resident who was relocated to another room within the facility; and for the destruction of a controlled substance schedule II drug. Residents #5 The findings include: 1. Facility staff failed to follow state regulations for Resident #5 who was relocated to another room within the facility. A review of Resident #5's record revealed a physician's telephone order dated October 25, 2008 that documented, "Transfer resident from [room] to room] ..." A social worker's note dated October 27, 2008, documented, "Resident transferred to [room] for administrative purposes ...Responsible party agrees to the transfer ...Physician notified" There was no evidence in the record that the facility complied with 44DCMR-1003.02 "Notice to resident and resident's representative "	{F 492}	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. Resident #5 was moved to a comparable room on the same unit, over the weekend because his call bell was not working. Although family stated they were notified there was no documentation on the record. Nurse was re-educated that although she was with a licensed pharmacist from the survey team she must have a nurse from the facility witness a wasted medication. Facility policy was reviewed and updated to include faxing a copy of the updated "Notice of Discharge or Transfer from this Facility or relocation within this Facility" form that the surveyors were able to provide us with. Staff was reminded to document the notification of appropriate individuals. Social Services has disposed of all the old forms and replaced them with the new ones. Social Service will continue to audit the fazing of notification to the Health Department. Any concerns will continue to be brought to the monthly Quality Improvement meeting for evaluation and intervention.	11/14/08

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{F 492}	Continued From page 17 A summary of the regulation follows: " (a) Whenever a resident is to be discharged, transferred or relocated, a facility representative shall give that resident and his or her representative both oral and written notice of the reasons for, procedures for contesting, and proposed effective date of the discharge, transfer, or relocation ...the oral and written notice shall be given ...at least 7 calendar days before a proposed relocation within the facility ....(d) written notice required ...shall at minimum contain: (1) The specific reason(s) stated in detail and not in conclusory language for the proposed discharge, transfer or relocation; (2) proposed effective date of the discharge, transfer, or relocation; (3) a statement that includes 'You have a right to challenge this facility's decision to discharge, transfer, or relocate you ...(continued as per the language of the regulation); (4) hearing request form; (5) name, address and telephone number of person charged with the responsibility of supervising the discharge, transfer or relocation; (6) the names, addresses and telephone numbers of the Long-Term Ombudsman program and local legal services organizations. (e) copies of the written notice required ...of this section shall be placed in the resident's clinical record and shall be transmitted to the Mayor' s designee ...Director of the Department of Human Services and the Long-Term Care Ombudsman ..." A face-to-face interview was conducted on October 28, 2008 at 1:00 PM with Employee #12, who acknowledged that a written notice including the above cited information was not completed. The record was reviewed October 28, 2008.	{F 492}		

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{F 492}	Continued From page 18 2.The facility staff failed to have a licensed nurse witness the wasting of a controlled substance schedule II drug in one (1) of eight (8) medication passes. The findings include: The facility ' s policy, 8.2 " Medication Disposal/Destruction " stipulates, " Wasted controlled meds are destroyed by two licensed nurses employed by the facility, and the disposal is documented on the accountability record on the line representing the dose ... " On October 28, 2008, at approximately 9:20 AM during the medication pass, a tablet of Methylphenidate 5mg for Resident JH4 dropped on the medication cart. Employee # 9 picked up the tablet and discarded it in the trash receptacle located on the side of the medication cart. There was no other licensed nurse to witness the disposal of the drug. A face-to-face interview was conducted on October 28, 2008 at approximately 12:15 PM with Employee #9. He/she acknowledged that another licensed nurse had not witnessed the wasting of the tablet.	{F 492}		
F 514 SS=D	483.75(l) (1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized.	10/29/08

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F 514	Continued From page 19 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility staff failed to document the administration of controlled substance on the October 2008 Medication Administration Record (MAR) for Resident JH1. The findings include: On October 29, 2008, at approximately 11:00 AM, a review of Resident ' s JH1 record revealed a physician ' s order dated September 28, 2008 that directed, " Percocet 5/325mg one (1) tab po [by mouth] q4hrs [every 4 hours] prn [as needed] - pain " . The October 2008 MAR was reviewed and indicated with signatures that Percocet was administered on October 2,3,4,5,6,7,8,9,10,11,12,17and 24 as evidence by initials entered in the allotted areas for the dates mentioned. The " Controlled Medication Utilization Record " indicated the Percocet was removed from the controlled substance cabinet and administered on the following dates October 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,17 and 24 2008. There was no evidence indicated on the October 2008 MAR that Percocet was administered on October 1, 13 (1700, 2200), 14 and 15.	F 514	Staff member who failed to document Percocet was counseled and provided with policy and procedure concerning medication Administration. Nurse Managers review medication regime at the end of each month. Pharmacist will continue to do monthly audits on all residents. Nurse educator will continue to do random Medication / Treatment Passes for compliance. They will continue to provide nursing with re-education if determined to need it. Nursing Management will do random audits of staff during Med Pass to identify and trends or concerns that need intervention. Any concerns or trends will continue to be brought to the monthly Quality Improvement meetings for evaluation and intervention.	

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F 514	Continued From page 20 A face-to-face interview was conducted on October 29, 2008 at approximately 11:00 AM with Employee #15. He/she acknowledged that the MAR did not indicate with signatures that the controlled substance was administered to Resident JH1. The record was reviewed on October 29, 2008.	F 514		

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