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 _____	09/10/2009

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 An annual re-certification survey was conducted at your facility on September 8 through 10, 2009. The following deficiencies were based on observations, staff interviews and record review. The sample size was 15 residents based on a census of 62 residents on the first day of survey.	F 000	Ingleside at Rock Creek is filing 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.	
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: ensure that a rubber gasket was secure on one (1) of one (1) bath tub, mount five (5) of five (5) multiplugs on the wall and dispose of 50 of 50 boxes of an expired nutritional supplement. The environmental tour was conducted on September 8, 2009 at 2:00 PM through 3:30 PM in the presence of Employees #3, 4, 7 and 8. The findings include: 1. The bath tub on the upper level was observed with the rubber gasket unattached around the base of the tub in one (1) of one (1) tub observed. 2. Multiplugs were observed on the floor and not mounted on the wall in rooms 44, 45, 70, 176 and 184 in five (5) of five (5) multiplugs observed.	F 253 F 253	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. The missing gasket will be repaired by 10-30-09. The Multiplugs noted in rooms 44,45,70,176 and 184 have been mounted on the wall. 2. Expired supplements were thrown away. We don't use that supplement in the facility. Rooms were checked for Multiplugs resting on floor. The ones that were identified will be mounted to wall. Supplements come to the central supply and they were audited for expired dates. None were found. During routine room rounds by maintenance they have added the Multiplugs to there audit. Any non-compliant plugs found will be fixed appropriately. Central supply staff will routinely check for expiration dates when supplements are stocked and will discard any supplements that are not used in the facility or have expired. Any issues will be brought to the monthly Quality Improvement meeting for evaluation and interventions.	10/30/09 10/30/09

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

Ann R. Schuff — Administrator — 10/12/09

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

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 _____	09/10/2009

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 253	Continued From page 1 1, 2009 in the upper level storage room across from the nurse's station. These findings were acknowledged by Employees #3, 4, 7 and 8 at the time of the observations.	F 253		
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) on 15 sampled residents, it was determined facility staff failed to complete a quarterly Minimum Data Set [MDS] assessment for Resident #4. The findings include: Resident #4 was admitted to the facility May 6, 2009. An admission MDS was completed May 19, 2009. The record lacked evidence of a quarterly MDS for the month of August 2009. A face-to-face interview was conducted with Employee #4 on September 8, 2009 at approximately 11:00 AM. He/she stated that Medicare PPS (Prospective Payment System) assessments were completed and a quarterly MDS was not required. According to the MDS User's Manual 2.0, Chapter 2, page 2-2, " OBRA regulations have defined a schedule of assessments that will be	F 276	A facility must assess a resident using the quarterly approved by CMS not less frequently than once every 3 months. Resident # 4 no longer resides at the facility. The facility's MDS coordinator left employment to return to school. She only gave two weeks notice and facility filled the position with the facilities previous MDS coordinator until a replacement could be found. She failed to code this assessment correctly. We have hired a new MDS coordinator and we are providing her with as much education and support so that she is successful in her position. We will continue to offer any assistance they may need to be compliant with dates and other regulations. Random audits will be done to check that MDS's are done timely per regulations. Any area of non-compliance found will be brought to the monthly Quality Improvement meeting for evaluation and intervention.	Begun 9-14-09 11/15/09

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 _____	09/10/2009

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 278	Continued From page 3 performed for a nursing facility resident at admission, quarterly and annually ...the Quarterly assessment is to be completed within 92 days of the R2b date of the Admission assessment. " The record lacked evidence of a Quarterly MDS assessment. The record was reviewed September 8, 2009.	F 278		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Resident#3 No longer resides at the facility. Resident #7 were corrected per guidelines. Resident #11 were corrected per guidelines. We hired an RN MDS coordinator who is following the MDS regulations to ensure that we remain compliant with dates, timeliness of assessments, and signatures. The MDS coordinator continues to audit MDS's for proper signatures and correct dates. She also audited charts to make sure their was no one left out of the schedule. She will be provided with any support or education to be compliant with regulations pertaining to her position. Nursing management will conduct random audits to identify any assessment not signed or dated appropriately. Any issues will be brought to the monthly QI meeting for evaluation and intervention.	10/30/09

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 _____	09/10/2009

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 278	Continued From page 4 A review of the quarterly MDS with an assessment reference date of August 29, 2009, revealed that the RN Assessment Coordinator failed to sign at Section R2a that the assessment was completed. According to the "MDS 2.0 User's Manual" page 3-212, " The regulations also require the RN Assessment Coordinator to sign and certify that the assessment is complete in Items R2a and R2b..." A face-to-face interview was conducted with Employee #9 on September 10, 2009 at 12:00 PM. He/she acknowledged the above cited findings. The record was reviewed September 10, 2009. 2. The RN Assessment Coordinator failed to sign and date Section ADa of an admission MDS for Resident #7. Resident #7 was admitted to the facility on November 15, 2008. The admission face sheet which included "Demographic Information" was completed but not signed by the RN Assessment Coordinator in Section ADa. According to the "MDS 2.0 User's Manual," page 3-27, "The RN Assessment Coordinator who worked on the Background (Face Sheet) Information at Admission must enter his or her signature on the day it is completed. Also, to the right of the name, enter the date the form was signed." A face-to-face interview was conducted with Employees #9 on September 10, 2009 at 12:00	F 278		

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 _____	09/10/2009

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 278	Continued From page 5 PM. He/she acknowledged the above cited findings. The record was reviewed September 10, 2009. 3. The RN Assessment Coordinator failed to sign Section R2 after all disciplines signed in Section AA9 for Resident #11. The quarterly MDS assessment was signed as completed by the RN Assessment Coordinator in Section R2 on June 30, 2009. A review of Section AA9 (b) revealed that the dietician completed Section K on July 2, 2009 and Section AA9(c) that the Recreational Therapist completed Section N on July 2, 2009. According to the " MDS 2.0 User's Manual " on pages 3-211 and 3-212, " Each staff member who completes any portion of the MDS must sign and date (at AA9) the MDS and indicate beside the signature which portions they completed ...The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. " A face-to-face interview was conducted with Employees #2 and 9 on September 10, 2009 at 11:15 AM. Both employees acknowledged the above cited findings. The record was reviewed September 11, 2009.	F 278		
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.	F 309	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.	10/30/09

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 _____	09/10/2009

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 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview for three (3) of 15 sampled residents, it was determined that facility staff failed to: obtain laboratory studies as ordered by the physician for one (1) resident, administer medication in accordance with the physician's orders for one (1) resident and clarify orders for oxygen saturation levels for one (1) resident. Residents #7, 8 and 10. The findings include: 1. Facility staff failed to obtain laboratory (lab) studies for Resident #7 as ordered by the physician. A review of Resident # 7's clinical record revealed an "Interim Order Form" dated June 8, 2009 signed by the physician and renewed July 30, 2009 that directed the following: "CBC (Complete Blood Count)...next lab [Laboratory] day and q [Every] 3 months Sept/Dec/ March/June. TSH (Thyroid Stimulating Hormone) next lab day and q 6 months June/Dec. " According to the resident's June 2009 MAR [Medication Administration Record], an entry on June 10 and 12, 2009, indicated " Refused " for " TSH, CBC. " There was no evidence in the record that the TSH and CBC lab studies had been obtained for Resident #7 at the time of this review. A face-to-face interview was conducted with	F 309	Resident # 7 had all labs drawn per Physician orders. Her record was reviewed to make sure it was noted on Physician order sheet correctly and in the TAR(treatment administration record. Resident #8 is receiving his medication as ordered. Resident #10 order was re-written so that the staff had parameters to work with. Staff are documenting the pulse ox in the TAR(treatment administration record). Charts were audited to make sure that ordered labs were done and on the medical record. The lab book continues to be checked daily to make sure all labs have been drawn and if a resident refuses that Physicians are notified. The TAR were audited to make sure pulse ox % were documented. Resident's who receive oxygen records were checked to make sure they were correctly written to address the monitoring of pulse ox %. Corrections were made where needed. The nurse who failed to document per facility policy and procedure was counseled. He was also re-inserviced on the correct way to administer medication, including signing the MAR(medication administration record) when med is given. Nursing management will do random med pass audits with this nurse focusing on signatures and continue to do random med pass audits with all nursing staff. Licensed nurses were re-inserviced on facility policy regarding writing orders with parameters and monitoring them,	10/30/09

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 _____	09/10/2009

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 309	Continued From page 7 Employee #3 on September 9, 2009 at approximately 12:30 PM. After reviewing the resident's clinical record, Employee #3 acknowledged the aforementioned findings. He/she stated: "The resident refused the blood draw on the next scheduled lab day as ordered and it was not followed up with. I have to renew the order and schedule another blood draw for tomorrow." The record was reviewed September 9, 2009. 2. Facility staff failed to administer medication in accordance with physician orders for Resident #8. A physician's order dated July 13, 2009, directed, "Coumadin 8 mg tabs by mouth every evening for Deep Vein Thrombosis prophylaxis." A review of the September 2009 Medication Administration Record (MAR) revealed that Coumadin was scheduled to be administered at 9 PM every evening. The spaces allotted for Coumadin administration on September 7 and 8, 2009 were blank, reflecting the medication was not administered. The record lacked evidence of the reason why the medication was omitted. A face-to-face interview was conducted on September 9, 2009 at approximately 10:00 AM with Employee #4. He/she acknowledged that the blank spaces on the June 2009 MAR revealed that Coumadin was omitted on September 7 and 8, 2009. He/she contacted the physician for directives. A face-to-face interview was conducted with Employee #14 September 10, 2009 at approximately 3:00 PM. He/she acknowledged that on September 7 and 8, 2009 his/her	F 309	monitoring pulse ox% in the correct place, and using the lab log so that residents who are refusing are rescheduled and physicians have been made aware. Nursing Management will continue with their random chart, MAR/TAR and lab log audits for compliance. Any issues will be brought to the QI monthly meeting for evaluation and intervention.	

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 _____	09/10/2009

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 309	Continued From page 8 signature was omitted from the MAR. He/she stated that the medication was given, but he/she forgot to sign the MAR. The medical record lacked evidence of Resident #8 receiving scheduled medication in accordance with the physician order and lacked documentation indicating why the Coumadin was not given. The record was reviewed on September 9, 2009. 3. A review of the clinical record for Resident #10 revealed facility staff failed to clarify a physician's orders for the assessment of oxygen saturation levels. Resident #10 was admitted to the facility March 28, 2008 and diagnoses included COPD (chronic obstructive pulmonary disease). Physician's orders dated September 2, 2009 directed, "O2 (oxygen) at 2L/min via nasal cannula as needed for shortness of breath and to maintain O2 sats (saturations) > 93%." The physician's order lacked evidence of monitoring parameters to be utilized in order to maintain the resident's O2 sats greater than 93%. A face-to-face interview was conducted with Employee #4 on September 9, 2009 at approximately 3:00 PM. He/she stated that licensed staff assessed the resident's O2 saturation via pulse oximetry every shift. He/she acknowledged that the record lacked evidence of scheduled pulse oximetry assessments and that the physician's orders lacked monitoring parameters. The record was reviewed September 9, 2009.	F 309		
F 311	483.25(a)(2) ACTIVITIES OF DAILY LIVING	F 311		

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 _____	09/10/2009

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 311 SS=D	Continued From page 9 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to follow through with physical therapist's recommendations for a functional maintenance program for ambulation for Resident #8. The findings include: Resident #8 was residing in the independent apartments of the facility and subsequently sustained a fall and fractured hip. The resident was admitted to the facility January 26, 2009. According to Section G (Physical Functioning and Structural Problems) of the quarterly Minimum Data Set assessment signed June 28, 2009, the resident was coded as requiring limited assistance of one person for locomotion, self propelled wheelchair as primary mode of locomotion and and used a walker. According to the most recent physical therapy care plan, rehabilitation services were provided July 22 through August 19, 2009 for gait training and therapeutic exercises. Review of the resident ' s record revealed that a PT " Weekly Progress Note " dated August 20, 2009, that directed, " ...arrange with caregiver to rolling walk patient for ambulation training	F 311	A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a) (1) of this section. Resident #8's functional maintenance plan for ambulation is written in his care plan and is documented in the TAR(treatment administration record) and continues to be walked daily when willing. Physical therapist put his functional maintenance plan in writing in the care plan. Staff training that was done prior to survey was documented. Residents who are on functional maintenance programs will have this documented in the TAR. This information will be updated quarterly with care plan review and adjustments will be made where appropriate. Nurse managers audit records quarterly with care plan reviews. Any issues of non-compliance will be brought to the monthly QI meeting for evaluation and interventions if needed.	10/30/09

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 _____	09/10/2009

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 311	Continued From page 10 maintenance program; discontinued from skilled PT to functional maintenance program for ambulation " There was no evidence in the resident's record that the functional maintenance program for ambulation was developed. A face-to-face interview was conducted on September 9, 2009 at approximately 12:40 PM with Employee #4. He/she acknowledged that functional maintenance program for ambulation was not developed. Employee #4 stated that, " I see him walked on a regular basis " . A face-to-face interview was held with the Employee #17 on September 9, 2009 at approximately 12:47 PM. He/she acknowledged that the caregiver was trained to assist Resident #8 on a functional maintenance program for ambulation. The medical record lacked evidence that a functional maintenance program for ambulation was developed per Physical Therapist recommendations. The record was reviewed on September 9, 2009	F 311		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2)Store, prepare, distribute and serve food under sanitary conditions. 1. five drains will be fixed by 10-30-09, to prevent back flow in the event of a sewer back up. The air gap space will be corrected. 2. the filter soiled with debris in the ice machine was replaced by contractor and cleaned by maintenance.	10/30/09

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 _____	09/10/2009

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 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen and upper and lower level pantries, it was determined that facility staff failed to: properly position five (5) of five (5) water supply outlets (drains) from equipment to prevent backflow in the event of a sewer back up, clean the filter on one (1) of one (1) ice machine in the main kitchen and use the correct serving scoop size for one (1) luncheon item and list portion size on the production sheet for two (2) items. The kitchen tour was conducted on September 8, 2009 from 10:00 AM through 12:10 PM and 12:30 PM through 1:15 PM in the presence of Employee #6. The findings include: 1. Five (5) of five (5) drains from equipment and sinks were not properly positioned over floor drains to prevent back flow in the event of a sewer back up. There was no air gap space to separate the water-supply outlet (drain) from a potentially contaminated source. 2. One (1) of one (1) ice machine in the main kitchen was observed with a filter soiled with debris. 3. On September 8, 2009 at 12:45 PM, the lunch meal was observed on the Lower Level. According to the production sheet for chopped meat the portion size was 4 ounces and a 6 ounce scoop was used. According to the production sheet the portion size	F 371	3. Kitchen serving staff were reinserviced on scoop sizes and why it's important to use the correct scoop size. They were Portion size was also discussed. Kitchen managers have and will continue to audit serving staff to make sure they adhere to portion size by following the production sheets. Production sheets are audited to make sure staff are following the correct portion size. If a portion size is omitted the Dietary management will correct the omission. Any issues found will be brought to the monthly Quality Assurance meeting for evaluation and interventions as needed	

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 _____	09/10/2009

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 371	Continued From page 12 for scallops was four (4) pieces. Two (2) scallops were served. Employee #16 stated at the time of the observation, " Four small scallops are served or two big ones. These are big scallops so I will serve only two. " The portion size for pureed bread was not listed on the production sheet. Employee #16 stated at the time of the observation, " The pureed bread is for residents who can't chew the hard rolls. We serve four ounces of pureed bread. " An 8 oz. scoop was used. Employees #6 and 16 acknowledged the findings at the time of the observations.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 15 sampled residents, it was determined that the physician failed to review the total plan of care as evidenced by failure to: document one (1) resident's non-compliance with care and follow up with ordered Lab [Laboratory] tests for one (1) resident. Residents #1 and 7. The findings include:	F 386	The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph © 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. Resident#1's physician documented this residents long standing refusal of treatments. Resident is competent and is able to make his own decisions. Staff explains risks to resident and he verbalizes understanding. Resident #7 had a CBC, CMP and TSH done. No new orders.	10/30/09

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 _____	09/10/2009

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 386	Continued From page 13 1. Physician failed to document non-compliance with monthly appointments for Foley catheter changes for Resident #1. A physician's order dated January 19, 2009 directed "Change [Foley catheter] once monthly by Urologist. " A telephone interview with the the urologist's office staff on September 8, 2009 at 11:30 AM, revealed that the resident's last visit was December 1, 2008. The urologist's staff stated that the resident cancelled the appointments dated February 17, 2009, May 18, 2009 and June 26, 2009. A review of the physician's progress notes failed to reveal any documentation of the resident's non-compliance with monthly appointments for Foley catheter changes or alternatives for Foley cathter care. A face-to-face interview was conducted with Employee #3 on September 8, 2009. He/she acknowledged that he/she was aware of the resident's non-compliance. The record was reviewed September 8, 2009. 2. The physician failed to follow-up on lab tests ordered for Resident #7. A review of Resident # 7's clinical record revealed an "Interim Order Form" dated June 8, 2009, signed by the physician and renewed July 30, 2009 that directed the following: "CBC (Complete Blood Count)...next lab day q [Every] 3 months Sept/Dec/ March/June " " TSH (Thyroid Stimulating Hormone) next lab	F 386	Medical Director was made aware and he talked with Physician for resident's #1 and #7. Explaining that even though it was mentioned in the nurses notes he still was responsible to include this information in his note and that he was aware of resident's behavior. The physician was also reminded that he is responsible for following up on labs he orders. In most cases the licensed staff follow up on labs but there is always a possibility that the lab could be missed. Licensed staff were re-inserviced on making sure if a resident's physician is not being responsive they are to call the medical director and inform nursing management so that the issue gets resolved. We will continue to do random chart audits for compliance in regards to labs. Any issues or trends will be brought to the monthly QI meeting for evaluation and interventions.	

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 _____	09/10/2009

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 386	Continued From page 14 day and q 6 months June/Dec. " According to the resident's June 2009 MAR [Medication Administration Record], an entry on June 10 and 12, 2009, indicated " Refused " for " TSH, CBC. " According to the " Physician's Progress Notes," the resident was seen by the physician on July 30, 2009. The progress note lacked evidence that the physician monitored, addressed and or followed up with the lab tests he/she ordered for TSH and CBC. A face-to-face interview with Employee #3 was conducted on September 10, 2009 at 12:15 PM. He/she acknowledged the above cited findings. The record was reviewed September 10, 2009.	F 386		
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, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff removed trash from an isolation room.	F 441	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. Resident #13 no longer resides at the facility. Prior to her discharge her nares cultures came back negative and she was removed from isolation. Employee #10 was re-inserviced on infection control. Her inservice records showed she had attended the many inservices given on infection control. We only have one resident	09/10/09 10/30/09

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 _____	09/10/2009

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 441	Continued From page 15 The findings include: Resident #13 was admitted to the facility on September 2, 2009. According to the admission orders signed by the physician on September 4, 2009, " Contact isolation for MRSA in nares. " According to a physician ' s order dated September 4, 2009, "Bacitracin ointment apply to nares BID (twice daily) x 14 days (MRSA colonization)." A culture of the nares is scheduled for September 21, 2009 to determine the isolation status of the resident. On September 9, 2009 at 10:10 AM, Employee #10 was observed removing a plastic bag of trash from Resident #13's room, walked down the hallway and disposed of the trash in the soiled utility room. A face-to-face interview was conducted with Employee #10 at the time of the observation. He/she acknowledged that trash should not have been removed from the isolation room in the manner he/she had done. The record was reviewed on September 9, 2009.	F 441	Who remains on isolation. We changed out infection control manual to include having a red bag in a resident's room who are on contact isolation. The red bag trash will be taken to the soiled utility room and placed in the red bio waste container. Any new resident put on contact isolation will have someone from nursing management make sure that the room is set up to meet CDC guidelines. Staff Development will continue to include infection control on their focused inservice list and will also continue to have it as part of the orientation program. Nursing management continues to always observe for compliance with facility's infection control policy and do one and one training immediately when non-compliance is observed. If any issues are identified they will be brought up at the monthly QI meetings for evaluation and intervention.	10/30/09
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:	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/10/2009

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 492	Continued From page 16 Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the social worker and activities staff failed to complete quarterly notes for Resident #4. The findings include: According to 22DCMR 3229.5, "The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly and revised as necessary." According to 22DCMR 3230.5, " The director of the activities program or his/her designee shall ...participate in the development of an interdisciplinary care plan and reassess each resident ' s responses to activities at least quarterly... " A. The Social Worker failed to conduct a quarterly assessment for Resident #4. A review of Resident #4's record revealed that the last social worker's note was dated May 8, 2009. There was no evidence in the record that the social worker documented in the resident's record subsequent to that assessment. A face-to-face interview was conducted with Employee #5 on September 8, 2009 at approximately 3:30 PM. He/she acknowledged the lack of social work notes scheduled for August 2009. The record was reviewed on September 8, 2009. B. The Activities Coordinator failed to conduct a	F 492	The reason there were no quarterly notes from activities and social services was related to the coding error of our previous MDS coordinator. We hired a new RN MDS coordinator who audits the resident schedule for MDS routinely to make sure that a resident was coded correctly so that their assessment will not be missed. The audit did not find any date inconsistencies. The RN MDS coordinator will be provided with education and support to make sure that the facility stays compliant with this tag. We will continue to monitor for any inconsistencies and these concerns will be brought to the QI monthly meeting for evaluation and intervention.	10/30/09

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 _____	09/10/2009

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 492	Continued From page 17 quarterly assessment for Resident #4. A review of Resident #4's record revealed the last documented activity progress note was dated May 13, 2009. There was no evidence in the record that the activities coordinator documented in the resident's record subsequent to that assessment. A face-to-face interview was conducted with Employee #15 on September 8, 2009 at approximately 3:45 PM. He/she acknowledged that there was no activity progress notes since May 13, 2009. The record was reviewed on September 8, 2009.	F 492		