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 ______	08/24/2012

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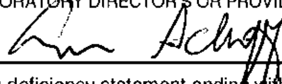
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 A recertification Quality Indicator Survey was conducted on August 20 through August 24, 2012. The deficiencies are based on observation, record review, resident and staff interviews for 31 sampled residents.	F 000	**F226 #1** 1. Resident #2's report of staff talking loudly outside of her room has since been reported to DOH. Our facility investigation did not reveal any evidence of verbal abuse.	10/9/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 31 sampled residents, it was determined that facility staff failed to report an alleged incident of verbal abuse and physical injury to the State Agency. Resident #2. The findings include: During a resident interview conducted August 21, 2012 at approximately 11:53 AM; Resident#2 was queried, " Have you ever been treated roughly by staff? " He/she responded; " Two female attendants talked rough to me in their language. I reported it and they were reprimanded. " Also, the resident stated that a nursing assistant struck his/her leg on the wheelchair while assisting him/her during a transfer from chair to bed. In response to a query whether or not the incident was reported, the resident stated, " I did not see any swelling	F 226	2. All incident reports/concerns have been reviewed by the DON and no further incidents of verbal misconduct was noted. 3. The DON, Social Worker, or designee will review all concerns and grievances regarding allegations of verbal misconduct and report it to DOH. In-services will be conducted on incident investigating and reporting by Staff Educator. 4. Weekly audits will be done by interdisciplinary team and to verify that all allegation of verbal abuse/misconduct are reported to DOH. Results will be forwarded to QA committee monthly for 3 months.	10/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Administrator

(X6) DATE: 10/18/12

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 226	Continued From page 1 or bleeding; so I did not report it to anyone. " A review of the facility ' s "Grievance/ Complaint Form" dated May 11, 2012 revealed that Resident #2 alleged that two (2) CNA ' s (Certified Nursing Assistants) stood in front of his/her door and talked loudly, sometimes speaking very loud in their language. It was noted that a facility investigation was conducted and corrective action was taken accordingly. There was no evidence that the allegation of verbal misconduct was reported to the state agency. A face-to-face interview was conducted with Employee #2 on August 24, 2012 at approximately 12:45 PM. Employee #2 stated that a telephone call was received on May 30th, 2012 from the resident ' s responsible party (RP), who alleged that Resident #2 sustained an injury to his/her leg while being transferred from wheelchair to bed. The RP stated that the resident did not tell anyone when it happened because she/he was afraid of getting someone into trouble. A review of the facility ' s investigation dated May 30, 2012 revealed that the allegation that Resident #2 sustained a physical injury during an assisted transfer was not substantiated. The allegation of physical injury verbalized by the resident ' s RP was not reported to the state agency. A face-to-face interview was conducted with Employees #2 and #14 on August 24, 2012 at approximately 12:45 PM. Both acknowledged that the aforementioned incidents of were not	F 226	**F226 #2** 1. Resident #2's report of allegation of physical injury by staff during a transfer has been reported to the DOH. As stated in the deficiency the findings did not substantiate the allegation of physical injury while being transferred. 2. An audit was done on all concerns/grievances regarding allegations of physical injury and no further allegations of physical injury was noted. 3. Licensed staff will be re-inserviced on completing and submitting incident reports of allegations of physical injury to DOH. 4. Weekly audits by interdisciplinary team will be done for 3 months to ensure all allegations of physical injury are reported to DOH. Results will be forwarded to QA Committee for analysis and review	10/9/12 10/1/12

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F 226	Continued From page 2 reported to the State Agency. Facility staff failed to report an alleged incident of verbal abuse and physical injury to the State Agency. The record was reviewed on August 24, 2012	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on an isolated observation, it was determined that facility staff failed to promote resident ' s dignity as evidenced by consistently talking into an electronic device while assisting residents. The findings include: Employee #13 was observed assisting residents in the common area community room on August 21, 2012 at approximately 4:00 PM. An electronic device that appeared to be a " headset, " with an ear and mouthpiece was observed positioned on his/her head. The employee was consistently speaking, in a tone that was easily heard and the conversation was not directed at the residents that the employee was assisting. He/she transported several residents via wheelchair to the community room and/or repositioned their seating arrangements. The employee was not	F 241	**F241** 1. The headset is a component of the Accunurse documentation system used by CNAs for Activities of Daily Living documentation. The employee was advised by Unit Manager not to use Accunurse while actively providing care for residents. 2. Observations of CNAs using the Accunurse documentation were done by DON and Unit Managers and no other CNAs were noted to be documenting while providing care for residents. 3. All nursing staff will be retrained on Accunurse documentation and maintaining resident's dignity during its use. 4. Random audits will be done weekly by Supervisors or designee to monitor use of Accunurse documentation by CNAs to maintain resident's dignity at all times. All audits will be reported monthly for 3 months to QA Committee for further review and actions.	8/31/12

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F 241	Continued From page 3 observed conversing with the residents that he/she assisted. A face-to-face interview was conducted with Employee #13 at approximately 4:30 PM on August 21, 2012. In response to a query regarding the purpose of the electronic device observed on his/her head, he/she responded that it was " Accu-nurse " an electronic medical device used for recording care delivery such as activities of daily living [ADLs]. The employee stated that he/she was talking into the device to record services that had been provided to residents. He/she stated that normally, the device is used when not involved in direct resident care, such as when changing linen. Employee #13 acknowledged that talking on the device while assisting residents was not appropriate. The observation was made on August 21, 2012.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, observations, staff	F 242		

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F 242	Continued From page 4 interview and record review, it was determined that facility staff failed to honor a resident's choice of bedtime in one of 31 sampled residents. Resident #114. The findings include: During the resident interview conducted on August 20, 2012 at approximately 3:00 PM, Resident #114 expressed that he/she does not get to choose his/her bedtime. He/she stated he/she is usually in bed by 10:00 PM and would prefer to go to bed around 11:00 PM or 12:00 Midnight. The medical record was reviewed for assessment of the resident ' s sleeping patterns and preferences. According to the undated Resident Data Collection Sheet, the resident stated the sleeping pattern varies. The record lacked documented evidence that follow-up was performed to determine the resident ' s actual or preferred sleep patterns. According to the OBRA Admission Minimum Data Set [MDS] with an ARD of August 3, 2012, Section F0400 - Interview for Daily Preferences - Item E was coded 2, indicating that it is somewhat important for the resident to be able to choose bedtime. The resident was observed on August 20, 21, 22, and 24, 2012 napping/sleeping in the mid-morning hours of 10:00 AM until 12:00 Noon, and was easily arousable. An interview with Employee #3 on August 23, 2012 at approximately 11:10 AM revealed the resident has never voiced any concern with sleep	F 242	**F242** 1. Resident # 114 is now discharged from facility. 2. All residents were interviewed and asked for their preferred time to go to bed and tis information was communicated on ADL flow sheet in the AccuNurse System. 3. CNAs will communicate with residents on a nightly basis to identify the time they would prefer to go to bed. All CNAs and Charge Nurses were inserviced on honoring resident's preferences for time of bed. 4. Audits will be conducted by Supervisors or designee 2 times per week for 4 weeks then monthly for 3 months to ensure that bed time preferences are granted to residents by staff. Findings will be reported to QA Committee monthly for review and action as appropriate.	10/5/12

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F 242	Continued From page 5 patterns. Employee #3 stated that the staff assesses the quality of sleep daily, and the resident usually replies that he/she has slept well. Employee #3 acknowledged there has not been any follow-up to determine the resident ' s preferred sleep patterns, as well as that the resident should be given a choice regarding bedtime schedule. The facility staff failed to offer the resident of choice regarding bedtime.	F 242	**F246** 1. Resident # 115 was interviewed and he reported that the call light is now answered within 5 minutes.	8/27/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on an isolated observation, it was determined that facility staff failed to respond with timeliness to a resident call light and call for assistance. Resident #115. The findings include: Facility staff failed to respond with timeliness to a resident ' s call for assistance as evidenced by an observation of repeated unanswered verbal calls for assistance by Resident #115 and an audible call light that was alarming	F 246	2. Rounding was done by DON and residents did not report any delay from staff in answering call lights. A new procedure was developed based on resident #115. When all nursing staff are engaged with other residents when a call bell is pushed, and other non-nursing staff on the unit will be asked to respond to the call bell. They will be instructed to go to a licensed nurse immediately after responding to the call bell. The licensed nurse will then determine how to respond to that call bell while still caring for the residents that staff are actively engaged with 3. Re-inservice of staff was done by Staff Educator on timely answering of call lights. 4. Unit Managers/Supervisors will monitor response times for call lights weekly for 4 weeks, then monthly for 4 months. The DON will also review the print out for call light response times and address with staff as warranted. Results will be submitted to QA Committee for review and action as necessary.	

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F 246	Continued From page 6 simultaneously (as resident called out verbally) that was not answered until brought to the attention of facility staff. An audible call light was heard alarming at the nurse ' s station at approximately 8:35 AM. This writer walked the length of the corridor, a medication cart was observed on the opposite end and the nurse managing the medication cart was occupied assisting a resident. No other staff were observed. As the call light continued to alarm, the resident repeatedly called out for assistance, " help. " The resident ' s door was open and he/she was observed seated in a chair with a breakfast tray of food on a table in front of him/her. In response to a query regarding what type of assistance was needed, Resident #115 responded that he/she needed to urinate and did not wish to soil his/her clothing. There was no evidence that the resident was in distress, however; assistance was needed. This writer presented back to the nurse ' s station, the call light alarm continued to sound and there was no staff in proximity of the station. Employee #4 was observed in the dining area and advised regarding the Resident #115 ' s request. Employee #4 stated that he/she did not hear the call light alarm and departed the dining room to assist Resident #115, at which point, the dining room was left unattended. A face-to-face interview was conducted with Employee #4 on August 22, 2012 at approximately 8:45 AM, after he/she assisted Resident #115. Employee #4 stated that all the	F 246		

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F 246	Continued From page 7 staff was occupied providing resident care and that he/she was focused on addressing the needs of the resident ' s in the dining room and was not aware of the call light, although audible in the dining room. Employee #4 stated that staff are assigned to monitor the dining room in 15-minute intervals beginning at 9:00 AM. Between 8:00 - 9:00 AM, the nurse manager monitors the dining room. Facility staff failed to respond with timeliness to a resident ' s call for assistance. The surveyor intervened to obtain assistance for Resident #115. The isolated observation was made August 22, 2012.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272		

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F 272	Continued From page 8 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: 0 Based on resident interview, observations and medical record review for two (2) of 31 sampled residents, it was determined that the facility staff failed to accurately code the Minimum Data Set [MDS] for oral/dental status for one (1) resident and an active diagnosis for one (1) resident. Residents #114 and 83. The findings include: 1. During the resident interview with Resident 114 on August 20, 2012 at approximately 3:00 PM, the resident responded that he/she has chewing problems because his/her dentures	F 272		

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F 272	Continued From page 9 "don't fit." He/she further stated he/she does not have his/her dentures here at the facility, by choice. According to the OBRA Admission MDS with an ARD date of August 3, 2012, Section L0200 - Oral/Dental Status - was coded Z, indicating no oral/dental problems. The resident was observed during the survey period without dentures in place. A review of the Personal Inventory Sheet dated July 27, 2012 revealed Resident #114 ' s dentures were brought to the facility. The medical record was reviewed relative to the oral assessment. According to the undated Resident Data Collection Sheet, the resident was noted to have complete upper and partial lower dentures, a few lower teeth, and [properly] fitting dentures. Review of the Personal Hygiene and Grooming section revealed the resident would require assistance for all personal hygiene and/or grooming. Neither section addressed whether the resident would wear the dentures. According to the Initial Nutrition Risk Assessment for Short-Term Stay dated July 30, 2012, the resident was edentulous, had his/her dentures in his/her room but preferred to eat without them. The diet had been modified to maintain weight and aid in healing/recuperation. The resident was receiving a mechanical soft diet as recommended by the Dietician, and was noted to consume 75 - 100 % of meals, based on appetite. According to the Nutrition Risk/Hydration Plan dated July 30, 2012, the staff identified the resident as having " ill-fitting dentures or don ' t	F 272	**F272 #1** 1. Resident # 114 is now discharged from the facility. 2. An audit was done of all residents with dentures. No other residents with ill-fitting dentures were coded incorrectly on MDS. 3. The MDS Coordinator was re-inserviced on accurate coding on MDS of residents with dentures or dentures that do not fit properly. 4. Random audits will be done by DON monthly to verify that MDS are coded accurately for residents that have ill-fitting dentures. Results will be reviewed and analyzed at monthly QA meeting.	8/27/12

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F 272	Continued From page 10	F 272		

like to wear my dentures."

According to interviews with the staff on August 22, 2012 at approximately 3:30 PM the resident had not voiced any concerns about eating or mouth problems. The resident's dentures were in his/her room and available to him/her, but preferred not wear them.

The facility staff failed to code the resident's ill fitting dentures on the admission MDS under Section L, Oral Dental Status [L0200(a)]. The record was reviewed August 22, 2012.

2. According to the OBRA Quarterly MDS with an Assessment Reference Date (ARD) date of July 17, 2012, Thyroid Disorder was not coded, at Section I3400 for Resident 83, as an active diagnosis. The following diagnoses were checked on the quarterly MDS: 10700 - Hypertension, 14800 Non Alzheimer ' s Dementia, 15300 Parkinson ' s Disease, 15800 Depression, and under additional active diagnoses - Hypoglycemia, Unspecified, Unspecified Episodic Mood Disorder, Memory Loss, and Edema.

On July 7, 2012 a telephone order was written at 12:15 AM for "Synthroid 25 mcq 1 PO Daily - Hypothyroidism Repeat TSH in 1 month". This telephone order was signed by the resident's physician on July 19, 2012. A physician telephone order dated August 6, 2012 at 9:00 PM indicated: " D/C (discontinue) Levothyroxine 25 mcq start Levothyroxine 50 mcq PO daily ". This order reflected an increase in Levothyroxine for a thyroid disorder.

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F 272	Continued From page 11 Further review of the medical record revealed laboratory tests for Thyroid stimulating hormone on July 6, 2012 and August 6, 2012. The July 6, 2012 result was 13.525 High (normal range 0.300 to 5.500) and on August 6, 2012 it was 13.247 High (normal range 0.300 to 5.500). The physician increased the Levothyroxine dosage from 25 mcq to 50 mcq based on the test result of August 6, 2012. The physician progress note dated August 2, 2012 documented, "Increase Thyroid ... Hypothyroidism under Rx (treatment)". Nursing staff initiated a "Hypothyroidism Care Plan" on July 17, 2012. The problem statement read as follows: "Potential for endocrine imbalance r/t (related to) TSH 13.525. An interview was conducted with Employee # 15, on August 27, 2012, confirmed the omission of Thyroid Disorder on the July 17, 2012 quarterly MDS as an active diagnosis under treatment.	F 272	**F272 #2** Resident #83 was newly diagnosed with Hypothyroidism. She was receiving the prescribed medication; while the physician and nursing staff was monitoring the appropriate laboratory blood levels for proper medication dosing. The resident was not adversely affected by "Thyroid Disorder" not being coded on the MDS. To assure not only that this resident but all IRC residents would not be affected by the same noted deficiency when there is a new diagnosis as indicated by the plan of care, the Charge Nurse will obtain a written order from the Physician for the new diagnosis. The diagnosis will be noted on the current POS, MAR, and TAR. This will be a systemic measure to ensure that the deficient practice does not recur. During each resident Care Plan Meeting the diagnosis list will be reviewed by the IDT members to assure that all resident's diagnosis list are appropriate and current. The Unit Manages, RN Supervisors, and Charge Nurses will monitor the accuracy of the diagnosis list while performing the monthly POS Turnover Process	8/27/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 279	Continued From page 12 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 31 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches to manage functional range of motion for one (1) resident and a community acquired pressure ulcer for another resident. Residents # 10 and 62. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches to address functional range of motion for Resident #10. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of February 27, 2012 under Section I, Active Diagnoses, Resident #10 ' s diagnoses included Arthritis, Pain in Joint (Lower Leg) and Stiffness of Joints. Section G, Functional Status revealed that Resident #10 was coded as having impairment of both lower extremities that	F 279	**F279 #1** 1. A care plan with goals and approaches was implemented for resident #10 to address resident's functional range of motion. 2. An audit was done on all residents with impaired range of motion and care plans are in place. 3. In-services were conducted with licensed nurses on the care plan process addressing functional status of residents. 4. Audits will be done weekly for 4 weeks, then monthly for 4 months by Care Plan Coordinator to ensure care plans for resident's functional status are in place. Finding will be reported to QA Committee monthly for review and action.	8/28/12

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F 279	Continued From page 13 interfered with daily functions. Section V, Care Area Assessment (CAA) Summary was triggered for the care area " ADL (activities of daily living) Functional/Rehabilitation Potential " and coded that the care area would be addressed in the care plan. The resident was observed seated with his/her legs extended on the leg rests of a wheelchair. A review of the physical therapy notes dated February 23, 2012 revealed: " Mobilization of knee to improve knee flexion ROM (Range of Motion). " A review of the care plans in the resident ' s clinical record lacked evidence that a care plan was developed with goals and approaches to address the resident ' s functional range of motion. A face-to-face interview was conducted with Employees #4 and 14 on August 24, 2012 at approximately 12:15 PM. After reviewing the record, Employee #14 acknowledged there was not care plan with goals and approaches to address range of motion. Facility staff failed to initiate a care plan with goals and approaches to address Resident #10 ' s functional range of motion of the lower extremities. The record was reviewed August 24, 2012. 2. Facility staff failed to develop a care plan for the management of a community acquired pressure sore for Resident #62.	F 279	**F279 #2** 1. A care plan with goals and approaches was put in place for resident #62 to address resident's pressure ulcer. Nurses were also reminded of the importance of documenting that the pressure ulcer was healing and then healed. 2. All residents with pressure ulcers currently were identified and care plan reviewed for presence of specific goals and approaches for pressure ulcers. 3. Licensed nurses were re-inserviced on how to initiate, develop, and update a care plan with specific interventions and goals for all residents with pressure ulcers. 4. The Care Plan Coordinator or designee will audit charts weekly for 4 weeks, then monthly for 3 months to assure that comprehensive care plans are in place for pressure ulcers. Findings will be presented to the QA Committee monthly.	8/28/12 8/28/12

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F 279	Continued From page 14 A review of the clinical record for Resident #62 revealed the resident was admitted with a stage I pressure sore of the sacrum as evidenced by the following nurse ' s admission note dated June 26, 2012 at 11:45 PM, " A 72 year old ...admitted ...sacral area noted with a stage I Pressure Sore, sore to touch ... " A review of the comprehensive care plan dated July 8, 2012 lacked evidence of problem identification, goals and approaches for the management of Resident #62 ' s community acquired Pressure Sore. The findings were acknowledged during a face-to-face interview with Employee #14 on August 24, 2012 at approximately 11:00 AM.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		

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F 329	Continued From page 15 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 31 sampled residents, it was determined there was no documented evidence for the increase of an anxiolytic medication for resident #83. The findings include: A physician telephone order dated July 18, 2012 at 9:10 PM read as follows: "D/C Buspar 5 mg twice daily. Start Buspar 10 mg 1 tab PO Twice daily anxiety comfort". The physician's progress note of August 2, 2012 documented, " Family had called regarding antianxiety medication ...[unable to decipher] increased agitation in their presence." Review of the Behavior Monitoring Flow Record for July 2012 and August 1, 2012 to August 22, 2012 revealed the entry "O" for day, evening, and night shifts indicating no behavior issues displayed. A review of the social service progress note dated July 6, 2012, documented the following: "... She has continued to display appropriate behavior and mood for this quarter ..."	F 329	**F329** 1. Resident #83 was reassessed by physician for use of Buspar and resident's behaviors are now documented on behavior monitoring sheet daily. 2. The behavior monitoring sheets for all residents receiving anxiety medication were reviewed for appropriate documentation that reflects behaviors. 3. Licensed staff were inserviced on how to complete and document on the behavior monitoring sheets when residents are receiving anxiety medication. 4. Audits will be conducted monthly by Unit Manager or designee to verify that documentation is present and is reflecting resident's behavior. DON will be forward results of audit to QA Committee for further review and action.	9/5/12

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F 329	Continued From page 16 Review of the nursing monthly summary for August 3, 2012, revealed a response to item #13 Behavior as "Calm" and Item #4 "Emotional Status" was blank. The nursing monthly summary dated July 6, 2012, revealed the following responses: item #13 Behavior was noted as "Calm" and Item 4 Emotional Status was documented as "Cooperative". A review of the nursing and social services progress notes and the behavior monitoring forms lacked evidence that resident #83 displayed anxiety behaviors as it relates to an increase in Buspar from 5 mg to 10 mg 1 tab twice daily on July 18, 2012. The findings were acknowledged during a face-to-face interview with Employee #15 on August 23, 2012 at approximately 9:30 AM.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observations made on August 23, 2012 at approximately 10:00 AM, it was determined that the facility failed to distribute,	F 371		

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F 371	Continued From page 17 store and serve food under sanitary conditions as evidenced by open food items such as pecans, walnuts, pretzels, mushrooms, one (1) of one (1) cherry pie, two (2) of two (2) pineapple upside down cakes, seasonings such as nutmeg, sesame seeds, cumin, soy sauce and ginger that were not dated and/or were stored uncovered, three (3) of three (3) soiled and worn food transportation carts, one (1) of six (6) employees with no hairnet in the kitchen, a soiled kitchen floor and during dining observation on August 20, 2012 food items from the steam tables on both units, were uncovered and exposed to dust and/or flying insects while plating meals for residents. The findings include: 1. Food items such as pecans, walnuts, pretzels, mushrooms and seasonings (nutmeg, soy sauce, ginger) in the main kitchen and one (1) of one (1) cherry pie, two (2) of two (2) pineapple upside down cakes, seasonings such as sesame seeds, cumin from the second floor kitchen were not dated and/or were stored uncovered. 2. Three (3) of three (3) food transportation carts and the kitchen floor were soiled and worn. 3. One (1) of six (6) employees in the kitchen wore no hairnet. 4. The kitchen floor was soiled. 5. Food items from the steam tables on the	F 371	**F371** 1. All food was immediately covered and dated. No residents were found to be affected by the event. 2. In-service training was conducted by the Executive Chef with the culinary staff on how to properly cover and date all food items. 3. Daily inspections are conducted by the chef's and dining room supervisors to ensure all food items are properly covered and dated. 4. Continuous reminders are made at daily stand up meetings	8/20/12

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F 371	Continued From page 18 upper and lower units were observed uncovered and exposed to dust and/or flying insects while plating meals for residents. Observations one (1) through four (4) were made in the presence of Employee # 6 who were present at the time.	F 371	**F454** 1. Immediately after meeting with the surveyors about the fire alarm systems at 5:58 p.m. on 8/20/12, a smoke watch plan was developed in accordance with the D.C Fire Marshall's Administrative Directive 03-2009.	8/20/12
F 454 SS=L	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review during the Life Safety Code Survey conducted on August 20, 2012 from 3:00 PM through 7:30 PM, it was determined that the fire alarm system failed to annunciate a signal when manual pull stations were activated on each floor of the Health Unit in eight (8) of eight (8) observations. The findings include: The fire alarm system failed to annunciate a signal throughout the facility when the manual pull station levers were pulled to activate the system inside and outside of Stairwells #6, 7, 8 and 9 near the elevator on the lower level on August 20, 2012 at approximately 4:30 PM. A second fire alarm test was conducted on the first floor (upper level) at Stairwell #6, 7, 8 and 9 on August 20, 2012 at approximately 4:45 PM, the system was activated by pulling the lever on the manual pull station and failed to illicit an audible response. A third test was conducted on August 20, 2012 at approximately 5:00 PM at each of the pull stations in both the upper and lower nursing units of the Health Center and there was no audible signal	F 454	The plan was accepted by the surveyors at approximately 8:30 p.m. on 8/20/12 as being appropriate and was implemented at that time. All staff were inserviced about the smoke watch plan commencing with the 3-11 p.m. shift on 8/20/12 and ending with the 7 am -3 9m shift on 8/21/12. At 8:01 a.m. on 8/21/12 when the Fire Marshall's office opened, a call was placed to them in accordance with the D.C. Fire Marshall's Administrative Directive 03-2009. We received permission to fax the plan to their office that had been implemented 12 hours ago on 8/20/12. *(See attached plan).* The plan was accepted by the Fire Marshall at 10:10 a.m. on 8/21/12. On 8/21/12 at 8:45 a.m. the contractor who services the fire alarm system was contacted about the pull station issues. At 9:59 a.m. he responded via email *(see attachment)* that a technician was enroute to Ingleside to diagnose and resolve the problems with the fire alarm system. A request to rescind the smoke watch was sent to the Fire Marshall at 4:11 p.m. on 8/24/12 as the system was back in working order. At 1:15 p.m. on 8/27/12, the Fire Marshall cancelled the fire watch as the system was in working order.	8/20/12 8/21/12 8/24/12

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F 454	Continued From page 19 elicited from the manual initiation. The facility Administrator was notified regarding the lack of audible alerts when the fire pull stations were activated. An Immediate Jeopardy was identified by the Department of Health at 5:58 PM on August 20, 2012. In response to the aforementioned notification, the facility Administrator acknowledged an awareness of a malfunction in the fire system and stated that a "Smoke Watch " plan had been implemented. However, there was no evidence that the facility Administrator was aware that the alarm pull stations were inoperable (lack of audible alerts). The Administrator was not able to provide documented evidence of the actual date that the "Smoke Watch " plan had been initiated nor written evidence of the plan. According to interview with the facility Administrator on August 20, 2012 at 5:30PM, the smoke watch plan included facility security staff making rounds (frequency not defined) throughout the building looking for smoke. Further, the "Smoke Watch" plan had not been approved by the District of Columbia Fire Marshall, nor had the State Agency been notified regarding the circumstances. On August 20, 2012, the facility administrator developed a " Fire-Watch " [note: " Smoke Watch " is a term used by the facility and " Fire Watch " is a term used by the D.C. Fire Department, however, both are used interchangeably] plan to monitor the building on an hourly basis and staff monitor the building on an hourly basis and staff were in-serviced, e.g. regarding the need to call 911 in the event of fire and locations of extinguishers The survey team reviewed and accepted a corrective action plan prior to departing the facility on August 20, 2012. Subsequently, the facility implemented their corrective action plan. The facility ' s Administrator contacted the Fire Marshall and submitted a Fire Plan, which was	F 454	**F454** 2. If an issue occurs with the fire alarm system in the future, the proper corrective actions will be put into place. This will include the possibility of a new smoke watch (in accordance with Fire Marshall's Administrative Directive 03-2009), contacting the contractor to repair the system, informing staff of any plan that has been put into place and inservicing staff about proper safety measures to ensure that residents are safe until the issue is resolved. 3. The fire alarm system is in good functioning order but was installed in the 1960's. To ensure that residents remain safe, a new fire alarm system is being installed *(see attachment)*. This will take several months to complete the installation. Once the new system has been approved by the Fire Marshall and the DCRA office it will become operational. 4. To ensure that the fire alarm system is properly working, the facility will continue to conduct the required fire drills on all three shifts as well as continue to have the contractor do the quarterly testing of the system. Staff will also continue to have the inservices about fire safety. If any problem occurs with the system it will be immediately reported to the contractor to fix.	

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F 454	Continued From page 20 approved on August 21, 2012 at 10:09 AM. The Immediate Jeopardy was lifted at 10:10 AM on August 21, 2012. After a review of the accepted Fire Watch plan by the Fire Marshall, it was determined that the deficient practice was lowered to a scope and severity of " F ". 2. Based on observations on August 20, 2012 and through staff interview, the facility's annunciator panel displayed a "trouble signal" (trouble code lamp was illuminated) indicating a malfunction within the facility's fire alarm system. The findings include: An interview with Employee #5 was conducted on August 20, 2012 at 3:00 PM. He/she acknowledged an awareness of a problem with the annunciator panel and that the annunciator trouble code lamp displayed a "trouble signal ". The employee stated that a contract technician had been to the facility on more than one occasion to service the system, but the repair had not been completed. On August 21, 2012, the facility's contracted technician was onsite to repair the system and Fire Inspectors from the District ' s Fire & EMS Division concurred that the safety measures in place were appropriate.	F 454		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was	F 456		

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F 456	Continued From page 21 determined that the facility failed to maintain essential equipment in safe operating condition as follows: one (1) of one (1) dishwashing machine, one (1) of one (1) ice machine, one (1) of one combination oven, one (1) of two (2) garbage disposals and one (1) of three (3) food warmers all from the main kitchen were in disrepair. On the second floor kitchen, one (1) of one (1) steamer, one (1) of one (1) kettle, one (1) of one (1) food warmer and two (2) of two (2) stoves were not fully operational. The findings include: 1. In the main kitchen, one (1) of one (1) dishwashing machine needed a conveyor belt; one (1) of one (1) ice machine and one (1) of one combination oven were out of order; one (1) of two (2) garbage disposals was leaking and one (1) of three (3) food warmers had a broken handle. 2. In the kitchen located on the second floor, one (1) of one (1) steamer and one (1) of one (1) kettle were non-functional; the doors to one (1) of one (1) food warmers were broken and two (2) of two (2) stoves were not fully operational. These observations were made in the presence of Employee #6 who acknowledged the findings.	F 456	**F456** 1. No residents were found to be affected by the event. 2. Work orders were pending at the time of the inspection with parts already on order for the dishwasher, ice machine, and combination oven • Dishwasher repair completed on 9/21/12 • Ice machine repair completed on 8/28/12 • Combination oven was replaced on 9/18/12 3. Work orders were submitted and repairs completed for the: • Garbage disposal on 8/29/12 • Food warmer handle on 8/27/12 4. Replacement of equipment had already been budgeted for in the 2013 budget: • Steamer out of order • Soup kettle out of order • Food warmer broken • 2 stoves not fully operational • No residents were affected by this event *Until all out of order or broken equipment has been replaced, equipment in the main kitchen is being used*	9/21/12 8/28/12 9/18/12 8/29/12 8/27/12
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		

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F 463	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 23, 2012 at approximately 12:00 PM, it was determined that facility staff failed to ensure that call bells in residents rooms are operational at all times as evidenced by call bells pull cords wrapped around the grab bar in five (5) of 28 residents rooms, a call bell pull cord that was too short in one (1) of 28 residents rooms, two (2) of four (4) inoperative call bells in the bathing spa on the lower level unit and one (1) call bell alarm light that was incorrectly placed outside the oxygen storage room on the upper level unit. The findings include: 1. Five (5) of 28 call bells pull cords were wrapped around the grab bar in the bathrooms of residents rooms #179, #183, #184, #186 and #193. 2. One (1) of 28 call bells pull cord was too short. 3. Two (2) of four (4) call bells did not initiate an alarm when tested in the lower level unit bathing spa. 4. The call bells alarm light for the upper level bathing spa is improperly mounted above the door of the oxygen storage room. These observations were made in the presence	F 463	**F463** 1. The identified call bell pull cords in the bathrooms were unwrapped and cord lengthened by Maintenance. Call light alarm and light in the bathing spa were repaired. 2. Check of all call bell pull cords and call bell alarms and lights were done and are functional and properly positioned. 3. All staff have been in-serviced on proper placements of call light pull cords in bathrooms. 4. Maintenance Director or designee will inspect bathing spas call light alarms/lights and call light pull cords for proper functioning and length of pull cords. Inspections will be done weekly for 4 weeks then monthly for 3 months and results forwarded to QA Committee for further action. The Unit Manager or designee will conduct random audits to verify that call light pull cords are properly positioned.	9/13/12

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F 463	Continued From page 23 of Employee #7 who acknowledged the findings.	F 463		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made during the survey, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects observed on one (1) of two (2) residents dining rooms The findings include: 1. Flying insects were observed in the upper level dining room during dining observation on the first day of the survey. These observations were made on August 20, 2012 at approximately 12:30 PM.	F 469	**F469** 1. No residents were found to be affected by this event of a fly in the dining area. 2. Pest control company was called and treatment was completed 3. Daily inspections are conducted by the dining services management team 4. Continuous reminders are made at daily stand up meetings to employees to make management aware of any insect issues.	8/24/12
F 492	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 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.	F 492		

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	095028	A. BUILDING ______ B. WING ______	08/24/2012

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

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F 492	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and records review, it was determined that facility staff failed to operate and provide services in compliance with accepted professional standards and principles as evidenced by the lack of documentation and record retention pertaining to quality control, safety and sanitation in culinary services including dish machine temperature records and food storage temperature records. The findings include: On August 23, 2012, at approximately 11:00 A.M. Employee #6 was asked to provide recent dishwashing machine, refrigerator and freezer temperature records. Employee #6 provided records from the years 2009 and 2010 and said that as far as he/she knew, there were no regulations that required the maintenance of such records and she/he had never been asked to provide them before. Upon review of the facility ' s Policy and Procedure (P&P's) manual for dietary services, the recommendation for the retention of records relating to dish machine and storage temperatures is one (1) year (Page 2, references/resources-2). On August 24, 2012 at approximately 11:00 AM, the surveyor asked Employee #1 whether or not the P&P's for dietary services are followed by the dietary services staff and he/she answered 'yes'.	F 492	**F492** 1. No residents were found to be affected by this event. 2. In-service training was conducted with all dietary managers to ensure proper record keeping policies are followed. 3. Temperature log binder was created for safekeeping of the monthly temperature and sanitation paperwork. 4. The Dining Director verifies monthly record keeping to ensure all temperature and sanitation paperwork is kept on file for a 12 month period.	8/22/12

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F 492	Continued From page 25 The observations were made in the presence of Employee #6 who acknowledged the findings.	F 492		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 31 sampled residents, it was determined that facility staff failed to consistently document the status of an altered skin integrity for one (1) resident and failed to record the status of an option to appeal liability notices for two (2) residents. Residents #29, 62 and 67 The findings include: 1. A review of Resident #29 ' s clinical record revealed facility staff failed to document the resident's or responsible party's response to the Notice of Medicare Provider Non-Coverage letter. The resident was admitted on May 31,	F 514	**F514 #1 & #3** 1. Residents #29 & # 67 were discharged prior to the survey. 2. A new policy was put into place to encourage residents/responsible parties to respond to the Medicare Provider of Non-Coverage letter. If the resident/responsible party declines to respond to the facility as to whether or not they wish to appeal the decision to end coverage, it will be duly noted in the resident record. Whenever possible a second staff member will be present to witness the resident/responsible party's decision to decline to respond to the letter. 3. The Director of Admissions, DON, and the Nurse Managers were in-serviced about the new policy regarding the Medicare Provider of Non-Coverage letter. 4. Audits will be done on Medicare Provider of Non-Coverage letters to ensure that the new policy has been put into effect and is being properly used.	9/14/12

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F 514	Continued From page 26 2012 for skilled care and received a notice indicating coverage for physical therapy services would end on June 30, 2012. The form included a section for patient or representative signature indicating the notice was received. Resident #27 ' s signature was present and dated June 18, 2012 on the form. The determination of the resident or responsible party's decision to appeal or not to appeal was not documented in the clinical record or on the notice form. Interviews were conducted with employee #16 on August 22 and 23, 2012 and employee #17 on August 23, 2012. Both staff confirmed that documentation was not recorded in Resident 29's clinical record as it pertains to his/her decision to appeal the notice. The resident was discharged on July 2, 2012. 2. A review of the clinical record for Resident #62 revealed facility staff failed to consistently document the status of the resident ' s altered skin integrity. A nurse ' s admission note dated June 26, 2012 at 11:45 PM revealed the resident was admitted with a community acquired pressure ulcer as follows, " A 72 year old ...admitted ...sacral area noted with a stage I Pressure Sore, sore to touch ... " A review of skin monitoring records (" skin sheets ") revealed the wound was assessed June 26, July 2nd and 9th 2012. The last assessment on July 9th revealed the pressure sore measured 7cm by 7cm, black in color with no depth or drainage. Physician ' s orders dated July 5, 2012 directed	F 514	**F514 #2** 1. Resident # 62 is now discharged from the facility. 2. An audit was conducted on all skin monitoring sheets and progress notes to ensure that the status of skin conditions are updated and clearly documented. 3. Licensed staff were re-educated on documenting, staging and description of wounds on skin sheets and in nursing progress notes. 4. Audits will be done on skin monitoring sheets and progress notes weekly for 4 weeks then monthly for 4 months to ensure that there is accurate documentation reflecting the current status of skin conditions. Findings will be forwarded to QA Committee for review and action.	10/5/12

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F 514	Continued From page 27 the following wound treatment orders, " Calmoseptine cream, apply to excoriated coccyx area every shift for 7 days. " A review of the Treatment Administration Record [TAR] for July 2012 revealed the wound treatment was administered for seven (7) days in accordance with physician ' s orders July 5 - 12, 2012. A physician ' s telephone order dated July 16, 2012 directed, " discontinue Calmoseptine to excoriated coccyx secondary to resolved; apply A&D ointment to perineal area for skin protection every shift. " The was no evidence in the nurse ' s progress notes or the skin monitoring records as to the status of the resident ' s altered skin subsequent to July 9, 2012. The findings were acknowledged during a face-to-face interview with Employee #14 on August 24, 2012 at approximately 11:00 AM. Facility staff failed to consistently document the status of Resident #62 ' s altered skin integrity. According to the discharge Minimum Data Set The resident was discharged from the facility on July 31, 2012. 3. A review of Resident #67 ' s clinical record revealed facility staff failed to document the resident's or responsible party's response to the Notice of Medicare Provider Non-Coverage letter. The resident was admitted on May 22, 2012, for skilled care and received a notice	F 514		

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F 514	Continued From page 28 indicating coverage for physical therapy services would end on June 11, 2012. The form included a section for patient or representative signature indicating the notice was received. Resident #67 ' s representative signed the notice on May 31, 2012. The determination of the resident or responsible party's decision to appeal or not to appeal was not documented in the clinical record or on the notice form. Interviews were conducted with employee #16 on August 22 and 23, 2012 and employee #17 on August 23, 2012. Both staff confirmed that documentation was not recorded in Resident 67's clinical record as it pertains to his/her decision to appeal the notice. The resident was discharged on June 12, 2012.	F 514		