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	HFD02-0008	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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L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 31 sampled residents, it was determined that the charge nurse 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:	L 051		

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L 051	Continued From page 1 1. Facility staff failed to initiate a care plan with goals and approaches to address 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 revealed under Section I (Active Diagnoses) included Arthritis, Pain in Joint (Lower Leg) and Stiffness of Joints; Section G0400 (Functional Limitation in Range of Motion); resident lower extremities are impaired on both sides. Upon observation the resident was observed seated in a wheel chair with his/her legs extended on the leg rest. According to the CAA (Care Area Assessment) Summary with an ARD date of February 27, 2012; ADL [Activities of Daily Living]/Rehabilitation Potential triggered and was to be address in care plan. 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 initiated with goals and approaches to address the resident ' s 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.	L 051	**L051 #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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L 051	Continued From page 2 Facility staff failed to initiate a care plan with goals and approaches to address resident ' s range of motion to 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. 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.	L 051	**L051 #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
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of	L 052		

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L 052	Continued From page 3 ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on an isolated observation, it was	L 052		

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L 052	Continued From page 4 determined that sufficient nursing time was not given as evidence by a failure to promptly respond to an activated 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 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 verbally 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	L 052	**L052** 1. Resident # 115 was interviewed and he reported that the call light is now answered within 5 minutes. 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.	8/27/12 8/27/12 8/27/12

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L 052	Continued From page 5 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 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. 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.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations of the facility ' s food service areas, it was determined that the facility failed to distribute, store and/or serve food under sanitary conditions as evidenced by open food	L 099		

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L 099	Continued From page 6 items such as pecans, walnuts, pretzels, mushrooms, one (1) of one (1) cherry pie, two (2) of two (2) pineapple upside down cakes and seasonings such as nutmeg, sesame seeds, cumin, soy sauce and ginger that were not dated and/or were stored uncovered. Additionally, food items from the steam tables during lunch service were observed 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 and seasonings such as sesame seeds, cumin from the second floor kitchen were not dated and/or were stored uncovered. 2. During a lunch dining observation on August 20, 2012 at approximately 12:30 PM, food items from the steam tables on the upper and lower units were observed uncovered and exposed to dust and/or flying insects while plating meals for residents.	L 099	**L099** 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
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion;	L 201		

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L 201	Continued From page 7 (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon	L 201		

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L 201	Continued From page 8 discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute 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 ensure that each medical record included the current status of resident's conditions as evidenced by a failure to: consistently document the status of an altered skin integrity for one (1) resident and the lack of documentation related to the status of an option to appeal liability notices for two (2) residents. Residents #29, 62 and 67 The findings include:	L 201	**L201 #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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L 201	Continued From page 9 1. 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, 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	L 201	**L201 #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 10/5/12

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L 201	Continued From page 10 sore measured 7cm by 7cm, black in color with no depth or drainage. Physician ' s orders dated July 5, 2012 directed 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	L 201		

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L 201	Continued From page 11 letter. The resident was admitted on May 22, 2012, for skilled care and received a notice 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.	L 201	**L206 #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
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute 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: 1. During a resident interview conducted August 21, 2012 at approximately 11:53 AM; Employee	L 206	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

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L 206	Continued From page 12 #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, resident complained of CNA hitting his/her leg on the wheelchair while being transferred back to bed. Stated, " I did not see any swelling or bleeding; so I did not report it to anyone. " An Abuse Prohibition Review conducted on August 23 and 24, 2012 at approximately 11:00 AM, an alleged violation was noted to have occurred on May 12, 2012 and May 30, 2012. A review of the facility ' s "Grievance/ Complaint Form" dated May 11, 2012 revealed 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. On May 30th, 2012, Employee #2 received a telephone call from [Resident ' s Responsible Party], who alleged that Resident #2 sustained an injury to his/her leg while being transferred from wheelchair to bed. [Responsible Party ' s name] stated resident did not tell anyone when it happened she was afraid of getting someone into trouble. The findings did not substantiate the allegation that physical injury occurred whiled being transferred from residents wheelchair to bed. There was no evidence that the facility investigated these incidents as an alleged physical injury and verbal abuse nor notified the State Agency.	L 206	**L206 #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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	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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L 206	Continued From page 13 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 alleged aforementioned incidents of physical injury and verbal abuse were not reported to the State Agency. Facility staff failed to report an alleged incident of verbal abuse and physical injury to the State Agency. Resident #2. The record was reviewed on August 24, 2012.	L 206	**L306** 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
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute 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	L 306		

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L 306	Continued From page 14 call bells in residents rooms were in good were in good working order 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 of Employee #7 who acknowledged the findings.	L 306		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from	L 426		

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L 426	Continued From page 15 debris that might provide harborage for insects and rodents. This Statute 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.	L 426	**L426** 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