Health Regulation & Licensing Administration

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 _____	08/18/2014

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

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L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on record review and staff interview for 40 of 40 residents with MDS assessments in a sample of 51 residents; it was determined that facility staff failed to ensure the MDS (Minimum Data Sets) assessments were readily and easily accessible to all professional staff members (including consultants; this information must also be made readily and easily accessible for review by the State Survey agency and CMS.) who need to review the information in order to provide care to residents. The findings include: According to Chapter 2.3 of the MDS 3.0 RAI Manual " In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record. Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident."	L 001	**L001 #1-5** 1. Residents #20 and #130 MDS records will be modified to reflect location and date CAA. Residents #128, #133, and #143 have been discharged from the facility. 2. All current MDS were reviewed for location and date of CAA documented in the MDS and were found to be in compliance. 3. MDS Coordinator was re-inserviced on complete documentation of MDS to include location and date of CAA. 4. The Director of Nursing (DON) or designee will conduct audits on all completed MDS prior to transmittal weekly x 4, then monthly x3 to ensure location and date of CAA is on MDS.	10/15/14 9/15/14 9/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine R. Schiff, Executive Director — TITLE — (X6) DATE: October 6, 2014

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L 001	Continued From page 1 During a review of clinical records on the residential care unit on August 14, 2014 at approximately 10:00 AM, Employee #6 was asked regarding the location to review residents ' MDS assessments, as they were not observed in the active clinical record. Employee #6 stated that the MDS assessments were maintained electronically and required a special access code that was maintained by the MDS Coordinator. He/she stated that he/she did not have access to the assessments and proceeded to contact the MDS Coordinator to obtain the MDS assessments. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the accessibility and availability of MDS assessments. He/she acknowledged that MDS ' were not accessible to clinical staff in the residential care areas. He/she stated that he/she is the MDS Coordinator and is normally the person who accesses and prints the MDS records when requested for review. There was no evidence that facility staff maintained MDS assessments on the active clinical records or in a manner where they were accessible and easily retrievable for professional review. Facility staff failed to ensure the MDS was easily retrievable, readily accessible, and on the resident's active clinical records. B. Based on clinical record review and staff interview, it was determined that facility staff failed to identify the location and date of Care	L 001		

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L 001	Continued From page 2 Area Assessment [CAA] information under Section V [V0200A] of Minimum Data Sets (MDS) for five (5) residents. Residents' #20, 128, 130, 133, and 143. The findings include: According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should include information on the complicating factors, risks and any referrals for the resident for this care area ... " 1. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #20. A review of Resident #20's Admission Minimum Data Set dated October 1, 2013 revealed the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #16 Pressure Ulcers and #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information for care areas [#2, 4, 6, 11, 16 and 17] was omitted. There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. A face-to-face interview was conducted with	L 001		

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L 001	Continued From page 3 Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014. 2. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #128. A review of Resident #128's Admission Minimum Data Set dated August 1, 2014 revealed the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcers, #17 Psychotropic Drug Use, #19 Pain, and #20 Return to Community Referral. The record revealed that the location and date of CAA information for care areas [#2, 4, 6, 11, 12, 16, 17, 19, and 20] was left blank. There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014.	L 001		

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L 001	Continued From page 4 3. Facility staff failed to identify the location and date of the Care Area Assessment (CAA) information on the admission Minimum Data Set (MDS) under Section V0200A for Resident #130. A review of Resident #130 's admission MDS with an Assessment Reference Date (ARD) of August 1, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" was selected for #2 Cognitive Loss/Dementia, #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence / Indwelling Catheter, #11 Falls, #12 Nutritional Status, #15 Dental Care and #16 Pressure Ulcers. The record revealed that the location and date of CAA information for care areas [#2, 5, 6, 11, 12, 15, and 16] was left blank. There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at approximately 10:20 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 14, 2014. 4. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #133.	L 001		

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L 001	Continued From page 5 A review of Resident #133's Admission Minimum Data Set dated August 5, 2014 revealed the Care Areas and the Care Planning Areas triggered for #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcers, #17 Psychotropic Drug Use, #19 Pain, and #20 Return to Community Referral. The record revealed that the location and date of CAA information for care areas [#5, 6, 11, 12, 16, 17, 19, and 20] was left blank. There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014. 5. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #143. A review of Resident #143's Admission Minimum Data Set dated August 4, 2014 revealed the Care Areas and the Care Planning Areas triggered for #5 ADL Functional/Rehabilitation	L 001		

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L 001	Continued From page 6 Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcer, and #20 Return to Community Referral. The record revealed that the location and date of CAA information for care areas [#5, 6, 11, 12, 16, and 20] was left blank. There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on the Minimum Data Sets (MDS) under Section V [V0200A] for five (5) residents reviewed. C. Based on observations, record review and interview for two (2) of 51 sample residents, it was determined that the facility staff failed to accurately code Minimum Data Sets (MDS) for one (1) resident receiving hospice services and one (1) resident for skin condition under Section M. Residents #10 and 52. The findings include:	L 001		

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L 001	Continued From page 7 1. Facility staff failed to accurately code the MDS for Resident #10 who was receiving hospice services. A review of the Resident #10 ' s clinical record revealed a Physician's order dated September 25, 2013 that directed, " [name] Hospice please evaluate resident secondary to debility." Hospice services were initiated in September 2013 and continued to the present. The Physician ' s order dated September 26, 2013 directed, " Pt (patient) admitted to [provider named] Hospice on 9/25/13 under the care of ...Dx [diagnosis] Debility. " A review of the Physician's Recertification form , revealed Resident #10 was certified to receive Hospice services on September 25, 2013 and was recertified to receive Hospice services on December 23, 2013, March 23, 2014 and May 20, 2014 (effective for 90-day periods). A review of the annual MDS dated July 18, 2014 revealed that the resident was not coded as receiving Hospice Care in Section O [Special Treatments, Procedures, and Programs]. The " Comfort Care/Hospice" care plan last updated on July 22, 2014 revealed, " Evaluation ... 7/22/14- remains on hospice care. Comfortable and no pain noted. " There was no evidence that facility staff coded the resident for receiving hospice services on the annual MDS. A face-to-face interview was conducted on August 15, 2014 at approximately 1:50 PM with Employee # 4. He/she acknowledged the	L 001	**L001 C. 1-2** 1. Residents #10 and #52 are discharged from the facility. 2. Audits of MDS for all residents on hospice and with skin alteration were done. All were coded correctly. 3. MDS Coordinator was re-educated on accurate coding of hospice and skin alterations on MDS. 4. The Director of Nursing (DON) or designee will audit MDS for accurate coding for residents on hospice care with skin alteration monthly x 4. Residents will be forwarded to QA committee for review and action.	9/15/14 9/15/14

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L 001	Continued From page 8 findings. The record was reviewed on August 15, 2014. 2. Facility staff failed to accurately code the admission Minimum Data Set [MDS] under Section M, Skin Conditions for Resident #52. An Admission nursing Assessment dated March 20, 2014 revealed, " Stage 2 wound on right buttock- 1 [cm] x 0.5 cm, [right] and left heels redness. " According to the facility ' s wound forms dated March 20, 2014, Resident #52 ' s skin was assessed as follows: " right heel- Stage I, left heel- Stage I, Right buttock- Stage II, and Left buttock Stage 2. " A review of the admission MDS assessment with an Assessment Reference Date (ARD) of dated March 27, 2014 revealed that Section M, Skin Conditions was coded as having one (1) Stage 2 pressure ulcer and one (1) Stage 1 pressure ulcer. There was no evidence that the admission MDS was coded to reflect the resident's two (2) stage II " buttocks " pressure ulcers and the two (2) Stage I " heels " pressure ulcers. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at approximately 10:15 AM. He/she acknowledged that the MDS was not coded to reflect the resident ' s unhealed pressure ulcers at each stage. Facility staff failed to accurately code the admission MDS for pressure ulcers. The record	L 001		

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L 001	Continued From page 9 was reviewed on August 14, 2014.	L 001		
L 008	3202.2 Nursing Facilities Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease. This Statute is not met as evidenced by: Based on review of 35 healthcare personnel records, staff interview, The District of Columbia Municipal Regulations for Nursing Facilities and the Centers for Disease Control's " Recommendations and Reports for Morbidity and Mortality Weekly Report Guidance for Evaluating HealthCare Personnel for Hepatitis B Virus Protection", it was determined, that the Nursing Facility, in nine (9) of 37 healthcare personnel (that provide residents' services) records, lacked documented evidence of Hepatitis B's immunization [a method of documenting the absence of communicable disease to help prevent the development and transmission of the disease and infection] or Hepatitis B ' s immunization declination. [Personnel 6, 31 to 38]. The findings include: Centers for Disease Control (CDC's) Standard. The U.S. Department of Health and Human Services Centers for Disease Control Recommendations and Reports for Morbidity and Mortality Weekly Report Guidance for Evaluating HealthCare Personnel for Hepatitis B Virus	L 008	**L008** 1. All identified staff had updated documentation for Hepatitis B on their file. 2. HR Manager will audit files for all staff's Hep B documentation and update accordingly. 3. Hep B will be offered to all new employees on first day of orientation. HR staff were educated by the Staff Development Coordinator to file the administration or declination form in staff file. 4. HR Manager will conduct monthly audits of all staff files to ensure Hep B documentation. Findings will be reported to QA committee for review and action.	9/5/14 9/5/14 10/6/14

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L 008	Continued From page 10 Protection and for Administering Post exposure Management Volume. 62 / Number. 10 December 20, 2013 stipulates: " Pre-Exposure Management Education and Infrastructure At the time of hire or matriculation, health-care providers and health-care institutions should provide training to [HealthCare Personnel] to improve recognition and encourage timely reporting of blood and body fluid exposures. The possibility that the post-exposure evaluation will cause the [HealthCare Personnel] to have time lost from work should not be a barrier to reporting. Institutions should ensure that [HealthCare Personnel] have rapid access to post-exposure testing and prophylaxis, including [Hepatitis Immunoglobulin] and [Hepatitis] B vaccine ... Vaccination All [HealthCare Personnel] whose work-, training-, and volunteer-related activities involve reasonably anticipated risk for exposure to blood or body fluids should be vaccinated with a complete, =3-dose [Hepatitis] B vaccine series. [Occupational Safety and Health Administration] mandates that vaccination be available for employees within 10 days of initial assignment...[HealthCare Personnel] trainees should complete the series before the potential for exposure with blood or body fluids, when possible, as higher risk has been reported during professional	L 008		

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L 008	Continued From page 11 training (e.g., residency training). Incompletely vaccinated [HealthCare Personnel] should receive additional dose(s) to complete the vaccine series....The vaccine series does not need to be restarted for [HealthCare Personnel] with an incomplete series; however, minimum dosing intervals should be heeded... Minimum dosing intervals are 4 weeks between the first and second dose, 8 weeks between the second and third dose, and 16 weeks between the first and third dose... [HealthCare Personnel] lacking documentation of [Hepatitis] B vaccination should be considered unvaccinated (when documentation for [Hepatitis] B vaccine doses is lacking) or incompletely vaccinated (when documentation for some [Hepatitis] B vaccine doses is lacking) and should receive additional doses to complete a documented [Hepatitis] B series. Health-care institutions are encouraged to seek documentation of "missing" [Hepatitis] B doses..., when feasible, to avoid unnecessary vaccination. [Occupational Safety and Health Administration] mandates that [HealthCare Personnel] who refuse [Hepatitis] B vaccination sign a declination statement (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10052&p_table=STANDARDS). [HealthCare Personnel] refusing [Hepatitis] B vaccination can obtain vaccination at a later date at no expense if the [HealthCare Personnel] is still covered under [Occupational Safety and Health Administration ' s] Bloodborne Pathogens Standard. Health-care	L 008		

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L 008	Continued From page 12 institutions should encourage [Hepatitis] B vaccination among [HealthCare Personnel] to improve [[Hepatitis B Virus] protection and to achieve the Healthy People 2020 target of 90% vaccination..." The Nursing Facility failed to: Ensure its personnel complied with applicable United States Department of Health and Human Services; Centers for Disease Control's recommendations for evaluating HealthCare Personnel for Hepatitis B Virus Protection. Nine (9) of the thirty-seven personnel records reviewed, lacked documented evidence of Hepatitis B's immunization or Hepatitis B's immunization declination. [Hepatitis B's immunization is a method of documenting the absence of the communicable disease. Hepatitis B's immunization subsequently helps prevent the development and transmission of the disease and infection]. The findings were acknowledged in a face-to-face interview with facility Personnel # 14 on August 13, 2014 at approximately 4:30 PM.	L 008		
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	L 051		

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L 051	Continued From page 13 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:	L 051		
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 ulcers: (c)Assistants in daily personal grooming so that	L 052		

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L 052	Continued From page 14 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 observations, record review and staff interview for three (3) of 51 sampled residents, it was determined that facility staff failed to ensure	L 052	**L052 # 1** 1. Resident #127 has been discharged from the facility. 2. An audit was completed of all data collection forms by Unit Managers and Supervisors and the collection forms were noted to have the oral/dental section completed. 3. The Staff Development Coordinator will inservice staff on assessment of oral dental status and the importance of documentation on the resident data collection form. 4. Audits will be conducted by Unit Managers and Supervisors weekly x 4, then monthly to verify that oral assessments are completed and documented on data collection forms. Results will be forwarded to QA committee for further review and action.	8/19/14 10/7/14

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L 052	Continued From page 15 sufficient nursing time was given to : complete an oral assessment for one (1) resident; administer a nutritional supplement (Med Pass 2.0) in accordance with physician ' s orders for one (1) resident and failed to consistently assess the status of skin alteration (bruises) and lower extremity edema for one (1) resident. Residents #127, 137 and 144. The findings include: 1. Facility staff failed to ensure sufficient nursing time was given to complete Resident #127's oral assessment on admission. This was a closed record review. A review of the facility ' s " Resident-Data Collection " form dated July 18, 2014 revealed, " Oral Assessment: Own teeth, Dentures: Upper: Complete. " The sections of the form to denote if dentures fit and the condition of the resident ' s teeth remained blank. The facility ' s form entitled " Initial Nutrition Risk Assessment for Short-Term Stay " under the section, " Oral/Dental Condition/Swallowing Disorder " , read " Complete upper denture. " A face -to- face interview was conducted with Employees #2 and #15 on August 15, 2014 at approximately 2:00 PM regarding the lack of completion of the " Resident - Data Collection " form. Both acknowledged the sections of the form that remained blank. The clinical record was reviewed on 8/15/14. Facility staff failed to complete the oral assessment section of Resident #127's Resident Data Collection form.	L 052		

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L 052	Continued From page 16 2. A review of the clinical record for Resident #137 revealed that facility staff failed to ensure sufficient nursing time was given to administer a nutritional supplement (Med Pass 2.0) in accordance with the physician ' s order. The physician ' s order dated July 29, 2014 at 4:45 PM directed, " Med Pass 2.0 [two] 2 ounces po (by mouth) BID [twice daily] 10:00 AM, 2:00 PM - document % consumed " A review of the July 2014 Medication Administration Record revealed that Med Pass was administered on July 30 and 31, 2014. A review of the August 2014 MAR revealed that Med Pass 2.0 was not administered to the resident from August 1 - 15, 2014 as prescribed. A face-to-face interview was conducted on August 15, 2014 at approximately 12:30 PM with Employee #4 who acknowledged the findings. The record was reviewed on August 15, 2014. 3. Facility staff failed to ensure sufficient nursing time was given to consistently assess Resident #144 ' s lower extremities for edema and assess the status of skin alteration (bruises) initially identified at the time of admission. A. Facility staff failed to ensure sufficient nursing time was given to consistently assess Resident #144 ' s lower legs for edema. A review of the 'Resident - Data Collection' Admission assessment dated August 7, 2014, revealed the nurse identified, assessed and documented the presence of 2[+] plus edema for Resident #144's right lower leg and 1[+] plus	L 052	**L052 #2** 1. Resident # 137's Med Pass 2.0 was restarted and documented as given starting 8/16/2014. Resident suffered no ill effects from not having received the Med Pass 2.0. 2. All residents with orders for Med Pass 2.0 are receiving supplements as ordered and documented as given. 3. Staff Development Coordinator will conducted retraining of licensed staff on assessment and documentation of residents with edema. 4. The Director of Nursing (DON) or designee will audit Medication Administration Records to ensure that physician orders for supplements are accurately carried over to the next month's Medication Administration Record. Audits will be done monthly. Results will be reported to QA committee for further review and action.	8/16/14 8/16/14 9/5/14

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L 052	Continued From page 17 edema for the left lower leg. Further review of the clinical record revealed " Skilled Daily Nurses Notes" dated August 7, 2014 through August 14, 2014 lacked documented evidence that Resident # 144 was assessed regarding the status of lower leg edema. A face-to-face interview was conducted with Employee # 4 on August 15, 2014 at approximately 3:20 PM. He/she acknowledged the findings. The clinical record was reviewed on August 15, 2014. Facility staff failed to ensure sufficient nursing time was given to consistently assess Resident #144' s lower legs for edema. B. Facility staff failed to ensure sufficient nursing time was given to consistently assess Resident #144's alteration in skin condition related to the multiple 'Bruises' identified on admission. A review of the 'Resident - Data Collection' Admission assessment dated August 7, 2014, revealed the nurse identified, assessed and documented the presence of multiple bruises which were reportedly acquired, prior to admission to the facility. The nurse identified the following locations of the various bruises on the anatomical diagram of the 'Resident - Data Collection' Admission assessment: Site # 1- Right Foot/ Toes Site # 2- Right Knee Site # 3- Left knee Site # 4- Left hand, anterior upper thumb	L 052	**L052 #3A** 1. Assessment and documentation in skilled nurses notes were done to check and reflect the status of edema of resident #144. Resident has since been discharged from the facility. 2. All residents identified with edema in lower extremities were checked and documentation is in place in skilled nursing notes. 3. Staff Development Coordinator will conduct retraining on assessment and documentation of residents with edema. 4. Audits will be done by the Director of Nursing (DON) or designee to verify appropriate assessments and documentations are in place in skilled nurses notes for residents with edema. Audits will be done weekly x 3, then monthly x 3, and then quarterly thereafter to ensure compliance. Results will be forwarded to QA committee for further review and action.	

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L 052	Continued From page 18 Site # 5- Left antecubital The clinical record including the Skilled Daily Nurses Notes dated August 7, 2014 through August 14, 2014 did not include subsequent documentation related to the multiple bruises identified on the anatomical Diagram of the 'Resident - Data Collection' Admission assessment. Additional review of the clinical record lacked documented evidence that Resident # 144 was consistently assessed for alteration in skin related to multiple 'Bruises' identified on admission August 7, 2014. The clinical record lacked documented evidence of a Skin Sheet for Resident # 144. A face-to-face interview was conducted with Employee # 4 on August 15, 2014 at approximately 3:20 PM. He/she acknowledged the findings. The clinical record was reviewed on August 15, 2014. Facility staff failed to consistently assess Resident #144's alteration in skin condition related to the multiple 'Bruises' identified on admission.	L 052	**L052 #3B** 1. Resident #144's skin was reassessed for bruising and skin sheets were implemented to monitor the bruises that he came to the facility with. 2. A 100% skin audit was completed to identify residents with bruises, all residents identified had skin sheets in place. 3. Nurses were inserviced regarding appropriate documentation of bruises on skin sheets. 4. The Director of Nursing (DON) or designee will audit for documentation of bruises on skin sheets weekly x 4, then monthly. Report will be forwarded to QA committee for review and action.	8/15/14 8/20/14 9/5/14
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 made on August 13, 2014	L 099		

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L 099	Continued From page 19 between 9:20 AM and 12:30 PM, it was determined that the facility failed to prepare food under sanitary conditions as evidenced by two (2) of two (2) soiled air curtains from the dishwashing machine in the main kitchen, One (1) of one (1) soiled grill in the main kitchen, one (1) of two (2) leaky soup vats in the main kitchen, one (1) of two (2) soiled convection units in the main kitchen , a non-functional pilot light from one (1) of one (1) gas stove in the main kitchen, one (1) of one (1) soiled convection oven unit in the Suites kitchen, foods such as four (4) of four (4) containers of salad dressing and one (1) of one (1) container of cream sauce that were expired, soiled floor surfaces in the Suites kitchen, 10 of 10 one-third hotel pans and 14 of 14 one-sixth pans that were stored wet and one (1) of two (2) one-half hotel pans and three (3) of 14 one-sixth hotel pans that were soiled. The findings include: 1. Two (2) of two (2) air curtains from the dishwashing machine in the main kitchen were soiled. 2. The grill in the main kitchen was soiled with burnt food residue in several areas. 3. One (1) of two (2) soup vats in the main kitchen was leaking at the on/off valve. 4. Both convection ovens from (1) of two (2) double convection ovens unit was soiled with burnt food residue. 5. The pilot light on the gas stove was broken. 6. Both convection ovens from one (1) of one (1) double convection oven units located in the Suites kitchen were soiled. 7. Foods such as four (4) of four (4) containers of salad dressing and one (1) of one (1) container of cream sauce were stored beyond their expiration date of August 12, 2014. 8. The floor surfaces in the Suites kitchen were	L 099	**L099** 1. No residents were affected by this deficiency. 2. Immediate corrective action was taken to resolve all identified issues respectively. • Throughout the production process, all food items will remain covered with parchment paper, foil, film wrap, or speed rack covers. • All identified wet food storage containers were re-washed and set to dry completely before being stacked. Utility in-service was conducted. • Utilities staff follow a weekly, daily, and monthly master cleaning schedule to ensure all kitchen equipment is free from soil. • Maintenance was made aware of the leaking valve on the Soup vat and broken pilot light. o Contractor came in and fixed both equipment concerns 3. Staff re-educated on proper food handling, hand hygiene, and equipment handling. 4. Food service managers conduct daily rounds to monitor food safety and cleanliness of all kitchens/dining areas. Managers offer frequent education and reminders to staff during daily stand up meetings. A thorough Food Safety & Sanitation Audit is also conducted monthly. All trends are tracked for quality assurance and will be reported to QA committee for further review and action.	8/13/14 8/20/14

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L 099	Continued From page 20 soiled with debris .... 9. Ten of ten one-third hotel pans and 14 of 14 one-sixth hotel pans were stored wet and ready for reuse. 10. One (1) of two (2) one-half hotel pan and three (3) of 14 one-sixth hotel pans were soiled with leftover food residue. These observations were made in the presence of Employee #18 and/or Employee #13 who acknowledged the findings.	L 099		
L 148	3226.8 Nursing Facilities No medication shall be administered to a resident more than sixty (60) minutes before or after the times stated in the prescription order by his or her physician. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 51 sampled residents, it was determined that facility staff failed to administer prescribed medications with timeliness. Resident #57. The findings include: During an observation on August 11, 2014 at approximately 11:00 AM, Employee #40 was observed preparing Resident #57 ' s medications for administration. A review of the Medication Administration Record (MAR) for August 2014 revealed that Resident #57 was scheduled to receive the following medications at 9:00 AM as prescribed by the physician: Amlodipine Besylate 2.5mg 1 tablet daily for hypertension; Aspirin 81mg 1 tablet daily for prophylaxis; Calcium Carbonate	L 148		

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L 148	Continued From page 21 with Vitamin D 500/400mg 1 tablet twice daily with food for supplement; Letrozole F/C 2.5mg 1 tablet daily for cancer; Lyrica 50mg 1 capsule three times daily; Namenda 10mg 1 tablet twice daily for dementia; Multi Vitamin 1 tablet daily for supplement. Employee #40 administered Resident #57 ' s medications (listed above) at 11:15 AM on August 11, 2014; greater than 2 hours post the prescribed administration time. A face-to-face interview was conducted with Employee #40 following the administration of the medication. He/she stated that he/she was " behind schedule " and acknowledged the findings. There was no evidence that Resident #57sustained any adverse effect from the delay in medication administration.	L 148	**L148** 1. Resident #57 had no adverse effects from late administration of medication. 2. All residents were monitored by Unit Managers for timely administration of medication and all received their medication in prescribed time. 3. Employee #40 was re-educated on medication administration and maintaining the right time. 4. The Unit Manager will randomly observe medication administration to ensure prescribed time, weekly. All findings will be forwarded to QA committee for review and action.	8/20/14 8/20/14
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on August 13, 2014 at approximately 3:00 PM, it was determined that facility staff failed to maintain resident environment free from accident hazards as evidenced by one (1) on nine (9) improperly secured oxygen tank on the upper level unit and a damaged call bell in one (1) of 22 resident ' s rooms. The findings include: 1. One (1) of nine (9) oxygen tanks stored in the oxygen room on the upper level unit was	L 214		

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L 214	Continued From page 22 stored on the floor and was not properly secured in an oxygen tank holder. 2. The call bell in one (1) of 22 resident ' s room (#198) was held together by clear tape and presented an accident hazard. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	L 214	**L214 #1** 1. The oxygen tank was immediately secured in an oxygen tank holder. 2. Oxygen tanks on both units were checked and all other tanks were found to be secured in oxygen tank holders. 3. Inservice was conducted by the Staff Development Coordinator for the licensed nursing staff on proper storage of oxygen tanks. 4. Maintenance Director and Unit Manager will check oxygen room to verify that oxygen tanks are secured in oxygen holders. Audits will be done weekly x 4, then monthly x 3. Oxygen tanks will then be monitored on a quarterly basis. Results will be forwarded to QA committee for further review and action.	8/13/14 8/13/14 8/20/14
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 on August 13, 2014 between 9:20 AM and 12:30 PM, it was determined that the facility failed to maintain call bells in resident ' s rooms readily accessible at all times as evidenced by a call bell that was wrapped around the grab bar in the bathroom of one (1) of 23 resident ' s rooms surveyed and a call bell that tied into a knot in one (1) of 23	L 306	**L214 #2** 1. The call bell held together with tape was replaced. 2. All call bells have been checked and found to be intact and functional by the Maintenance Director. 3. All nursing, housekeeping, maintenance and rehab staff have been inserviced on reporting and replacing damaged call bells and having them replaced promptly. 4. The Maintenance Director will round weekly to verify that all call bells are intact and functional. Audits will be done weekly x 4 then monthly x 3 and quarterly thereafter. Report will be forwarded to QA committee to review and action.	8/13/14 8/13/14 9/5/14

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L 306	Continued From page 23 resident ' s rooms surveyed. The findings include: 1. The call bell in the bathroom of room #196 was wrapped around the grab bar, could not be activated and was not readily accessible, one (1) of 23 resident ' s rooms. 2. The call bell in one (1) of 23 resident ' s rooms (#199) was tied into a knot at the call bell housing and was not readily accessible. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	L 306	**L306** 1. The call bell in the bathroom of room #196 was unwrapped from the grab bar and made accessible for use. The call light was unknotted from the call bell housing unit and is accessible for residents. 2. The Director of Nursing (DON) conducted an audit and all call bells are accessible for all residents to use. 3. Staff was re-inserviced on keeping call bells unwrapped to be accessible at all times to all residents. 4. Compliance will be monitored by the Interdisciplinary Team during rounding to ensure that call bells are unwrapped, unknotted, and within reach for residents. Audits will be done weekly x 4, then monthly. Trends will be reported to QA Committee for review and action.	8/18/14 8/22/14 9/5/14
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on August 13, 2014 at approximately 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by a soiled and marred room on the upper level unit, clutter in one (1) of 23 resident ' s rooms and missing knobs to a resident ' s dresser and nightstand in one (1) of 23 resident ' s rooms. The findings include: 1. A room on the upper level unit identified as ' weighing room ' by a piece of paper posted on the door, was cluttered with two (2) fall mats and	L 410	**L410 #1** 1. Fall mats and trash bags were removed from the "Weight Room". The floor was cleaned and the wall was cleaned and painted. 2. All storage areas were checked and found to be clean and free of clutter. 3. Facility staff was re-educated on cleanliness and proper storage of equipment. 4. Facilities Director or designee will check storage rooms weekly x 4 then monthly x 3 and then quarterly on an ongoing basis to ensure cleanliness. Reports will be forwarded to QA for further review and action.	8/13/14 8/13/14 8/19/14

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L 410	Continued From page 24 a trash bag stored on the floor, a floor scale and a bed scale; The floor was soiled and the walls were marred. 2. One (1) of 23 resident ' s rooms (#177) was cluttered with approximately 10 to 12 cardboard boxes that were stored on the floor and numerous pages of newspapers that were scattered over the boxes. 3. 11 of 14 knobs were missing from the resident ' s dresser and nightstand located in room #177, one (1) of 23 resident ' s rooms. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	L 410	**L410 #2-3** 1. Resident # 177 room was de-cluttered by Maintenance and Housekeeping staff. Dresser was replaced. 2. All other rooms were checked and no other resident rooms were found to be cluttered or with furniture knobs missing. 3. Housekeeping will check residents' room daily to clean and remove clutter. 4. Unit Manager or designee will monitor resident rooms weekly x 4 to ensure that resident's room is clean and organized. Reports will be forwarded to QA committee for review and action.	8/13/14 8/13/14
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on August 13, 2014 between 9:20 AM and 12:30 PM, it was determined that the facility failed to maintain essential equipment in good operating condition as evidenced by one (1) of one (1) dishwashing machine in the main kitchen and one (1) of one (1) dishwashing machine in the suites kitchen that failed to operate as intended. The findings include: 1. The high temperature dishwashing machine located in the main kitchen failed to reach a final rinse temperature of a minimum of 180 degrees Fahrenheit on three (3) consecutive complete cycles. 2. The Suites kitchen low temperature dishwashing machine log was improperly	L 442		

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 _____	08/18/2014

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) COMPLETE DATE
L 442	Continued From page 25 recorded as a high temperature dishwashing machine from August 1, 2014 through August 12, 2014. The rinse temperature was consistently documented at 180 degrees Fahrenheit during breakfast, lunch and dinner and dietary staff failed to test the final rinse solution for proper bleach chemical concentration of 50 parts per million (PPM). These observations were made in the presence of Employee #18 who acknowledged the findings.	L 442	**L442** 1. No residents were affected by this deficiency. 2. Immediate corrective action was taken to resolve all identified issues respectively. • High temp dish machine was placed out of order until contractor was able to replace parts to assist machine in reaching proper temperature o Procedure was followed and all meal were service on emergency paper supplies until dish machine was running properly. o All pots and pans went through the three compartment sink and allowed to air dry before being stored away. o Contractor confirmed dish machine was reaching proper temperature. • Low temp dish machine was placed out of service until contractor was able to verify proper sanitizer level and Department of Health employee was able to verify proper chemical levels. o Procedure was followed and all meal were service on emergency paper supplies until dish machine was running properly. 3. Utilities staff were inserviced on the low temperature dish machine and how to properly check the chlorine sanitizer solution. 4. Management will continue to monitor to ensure temperatures and sanitizer are reaching correct levels and are being read and recorded properly. Management will monitor daily x 1 month, weekly x 4, then monthly x 3. Reports will be forwarded to QA committee for further review and action.	8/25/14 8/14/14