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	095031	A. BUILDING _____ B. WING _____	01/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK MANOR NURSING CTR	2131 O STREET NW WASHINGTON, DC 20037

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L 000	Initial Comments An annual licensure survey was conducted on January 17 through 20, 2006. The following deficiencies were based on record review, observations and interviews with staff and residents. The sample included 25 residents based on a census of 165 residents on the first day of survey and one (1) supplemental resident.	L 000		
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 observation, staff interview and the review of the clinical record for one (1) of 25	L 051		

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L 051	Continued From page 1 residents, it was determined that the charge nurse failed to reassess Resident #17 after a report of edema to the right lower extremity. Resident #17. The findings include: On January 17, 2006 at approximately 9:40 AM the resident was observed sitting in a wheel chair with his/her leg in a dependent position with edema to the right foot and leg. During the review of the clinical record, a nurse's note dated January 10, 2006 at 5:58 AM indicated, " Alert and verbal, CNA alerted me to the fact that the resident's right lower extremities were swollen, right foot elevated with pillow - no agitation noted this shift. Will continue to monitor temperature (T) 98- pulse (P) 70, respiration (R) 20, and blood pressure (B/P) 140/70. Right lower extremities edematous, next shift will follow up. " The 24-Hour Nursing Report was reviewed for January 9, 2006. Documentation on the night shift report indicated, "Right lower extremity swollen edematous +3, B/P 140/70, R 20, T 98 and P 70." According to the 24-Hour Nursing report and a physician's progress note dated January 13, 2006 , the resident was visited by the physician. However, there was no documentation regarding edema of the resident's right lower extremity. On January 17, 2006 at approximately 10:30 AM, the RCC (Resident Care Coordinator) was interviewed and acknowledged the edema. He/ She indicated that he/she was not aware of the edema to the resident's right lower extremity on January 10, 2006.	L 051	1. Resident #17 was assessed and transferred to the hospital for treatment. 1/17/06. 2. All residents with lower Extremity Edema were reassessed and checked to ensure compliance. 3. All Nursing Staff will be in-serviced on daily assessment of all residents during AM Care and to report abnormal findings to the RCC and onto the physician. 2/28/06. 4. All deficient practices regarding physician documentation will be discussed in the monthly Risk Management/QA meeting, quarterly QA meeting and reported immediately to the Administrator for further remedial actions.	3/6/06

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L 051	Continued From page 2 Facility staff failed to reassess the resident's right lower extremity after January 10, 2006 when it was observed with edema. The record was reviewed on January 18, 2006.	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 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;	L 052		

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L 052	Continued From page 3 (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, it was determined that facility staff failed to maintain proper procedures to help prevent the development and transmission of disease and infections by: failure to wash a bedside table before reuse; walking on a bed side mat; and residents observed seated on soiled benches in the court yard. Resident # 17. The findings include: 1. Facility staff failed to clean an over bed table after feeding Resident #17 and reusing it for another resident. On January 17, 2006 at approximately 12:15 PM a CNA was feeding Resident #17 who was in a semi-private room, with two (2) over bed tables. His/Her lunch was placed on one (1) over bed table. The other over bed table was in use with supplies for Resident #17's treatment that was to be administered by the licensed nurse after the resident ate his/her lunch. The CNA completed feeding Resident #17,	L 052	1. The protective floor mat for resident #17 was sanitized. 2/19/06. 2. All residents' protective floor mats were checked and sanitized to ensure compliance. 3a. All residents' with fall protective floor mats were identified as a preventative measure to alert staff not to walk on the floor mat. 3b. All staff will be in-serviced on Infection control measures regarding residents' fall protective floor mats and Team Leader/RCC's (Resident Care Coordinators) will monitor for compliance. 4. Problems with residents' with fall Protective floor mats relating to infection control will be discussed in the quarterly QA meeting for remedial action.	3/6/06

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L 052	Continued From page 3 (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, it was determined that facility staff failed to maintain proper procedures to help prevent the development and transmission of disease and infections by: failure to wash a bedside table before reuse; walking on a bed side mat; and residents observed seated on soiled benches in the court yard. Resident # 17. The findings include: 1. Facility staff failed to clean an over bed table after feeding Resident #17 and reusing it for another resident. On January 17, 2006 at approximately 12:15 PM a CNA was feeding Resident #17 who was in a semi-private room, with two (2) over bed tables. His/Her lunch was placed on one (1) over bed table. The other over bed table was in use with supplies for Resident #17's treatment that was to be administered by the licensed nurse after the resident ate his/her lunch. The CNA completed feeding Resident #17,	L 052	1. Bird dropping on all courtyard benches were cleaned. 1/20/06. 2. Benches on the courtyard, were checked by the Director of Maintenance and found to be in compliance. 3. The Director of Maintenance will check courtyard benches daily during courtyard clean up and during smoking period to ensure compliance. 4. Problems related to bird droppings, on benches and courtyard will be reported to the Director of Maintenance on to the Administrator for remedial action and will be discussed in the quarterly QA meeting.	3/6/06

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L 052	Continued From page 3 (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, it was determined that facility staff failed to maintain proper procedures to help prevent the development and transmission of disease and infections by: failure to wash a bedside table before reuse; walking on a bed side mat; and residents observed seated on soiled benches in the court yard. Resident # 17. The findings include: 1. Facility staff failed to clean an over bed table after feeding Resident #17 and reusing it for another resident. On January 17, 2006 at approximately 12:15 PM a CNA was feeding Resident #17 who was in a semi-private room, with two (2) over bed tables. His/Her lunch was placed on one (1) over bed table. The other over bed table was in use with supplies for Resident #17's treatment that was to be administered by the licensed nurse after the resident ate his/her lunch. The CNA completed feeding Resident #17,	L 052	1a. Over bed table of resident # 17 as well as that of the roommate was immediately cleaned and sanitized. 1b. The nursing staff was immediately in-serviced on proper use and sanitation of over bed tables regarding infection control. 2. All nursing staff will be in-serviced on sanitizing of over bed tables after each use to prevent cross contamination. 2/15/06. 3. On-going in-services will be conducted to remind staff to always sanitize over bed table after being used by another resident. RCC's (Resident Care Coordinators) and team leaders will monitor for compliance. 4. All deficient practices relating to Infection Control of over bed tables will be discussed in the monthly Risk Management/QA and quarterly QA meeting for further remedial action.	3/6/06

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L 052	Continued From page 4 removed the lunch tray from the table and proceeded to place the over bed table at the foot of the resident's room mate's bed. The surveyor was leaving the room and another CNA was entering the room with a lunch tray for Resident #17's roommate. The over bed table was not washed before the CNA placed the tray on the table. The tray was uncovered and the resident started eating his/her lunch. On January 18, 2006 at approximately 11:00 AM a face-to-face interview was conducted with the RCC (Resident Care Coordinator) who acknowledged that the CNA failed to wash the table and indicated that the staff was in-serviced recently on infection control practices. 2. A CNA was observed walking on a fall protective mat. On January 17, 2006 at approximately 5:00 PM a CNA was preparing to feed Resident #17 his/her dinner. A covered fall protective mat was on the floor at the resident's bedside. The CNA bought the dinner tray to the resident's bedside, stepped on the mat and placed the tray on the over bed table. After placing the tray on the table, the CNA placed the folded mat against the wall. On January 18, 2006 at approximately 11:00 AM a face-to-face interview was conducted with the RCC who acknowledged that the CNA stepped on the mat and indicated that the staff was in-serviced recently on infection control practices. 3. Residents were observed seated on wooden benches in the courtyard that were soiled with bird droppings on the seat and back surfaces in three (3) of four (4) observations at approximately	L 052		

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L 052	Continued From page 5 12:30 PM on January 18, 2006.	L 052		
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by soiled sprinkler heads directly over cooking areas. These findings were observed in the presence of the dietitian. The findings include: Sprinkler heads located directly over food preparation areas were soiled with accumulated dust and debris in three (3) of four (4) observations at approximately 9:20 AM on January 17, 2006.	L 359	1. Sprinkler heads located directly over food preparation area will be replaced. 2. All sprinkler heads located in the cooking area was checked and changed to meet compliance. 3. The Food Service Director and the Director of Maintenance will monitor monthly to ensure compliance. 4. The Director of Food Service will report problems of kitchen sanitation to include sprinkler heads to the Administrator and will reports will be given at the quarterly QA meeting for remedial action.	3/6/06
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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled and stained privacy curtains, excessive telephone and	L 410		

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L 052	Continued From page 5 12:30 PM on January 18, 2006.	L 052	1a. Privacy curtains in rooms 113, 117, 120, 205, 215, 403, 404, 413, 506, 517 were Cleaned.1/25/06. 1b. Room 207 is a private room and never had privacy curtains. 1c. Contract bids are taken to replace privacy curtains on floors 2, 4 and 5. 2. All privacy curtains have been checked and cleaned. 3. All privacy curtains will be checked daily and during weekly Grand Rounds. 4. The Director of Environmental Services will submit reports related to privacy curtains immediately to the Administrator and report will be given in the quarterly QA Meeting.	3/6/06
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by soiled sprinkler heads directly over cooking areas. These findings were observed in the presence of the dietitian. The findings include: Sprinkler heads located directly over food preparation areas were soiled with accumulated dust and debris in three (3) of four (4) observations at approximately 9:20 AM on January 17, 2006.	L 359		
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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled and stained privacy curtains, excessive telephone and	L 410		

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L 052	Continued From page 5 12:30 PM on January 18, 2006.	L 052		
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by soiled sprinkler heads directly over cooking areas. These findings were observed in the presence of the dietitian. The findings include: Sprinkler heads located directly over food preparation areas were soiled with accumulated dust and debris in three (3) of four (4) observations at approximately 9:20 AM on January 17, 2006.	L 359	1. Unsecured telephone cords in rooms 102, 117, 504, and 520 were secured. 1/18/06. 2. All telephone cords in residents' rooms were checked by the Director of Maintenance and found to be in Compliance. 3. The Director of Maintenance will check telephone cords weekly during Grand Rounds and record them in the Maintenance logbook to ensure compliance. 4. Problems related to telephone cords, will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discuss in the quarterly QA meeting.	3/6/06
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 during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled and stained privacy curtains, excessive telephone and	L 410		

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L 410	Continued From page 6 cable wires on floors in ambulating areas, Geri chair armrests were torn and damaged, and housekeeping closets lacked racks for storing cleaning equipment off floor surfaces. These findings were observed in the presence of the Housekeeping and Maintenance Directors. The findings include: 1. Privacy curtains were soiled and stained in the following residents rooms: First floor rooms 113,117, 120 and 130 in four (4) of 13 observations between 2:56 PM and 3:45 PM on January 17, 2006. Second floor rooms 205, 207 and 215 in three (3) of 13 observations between 2:16 PM and 3:40 PM on January 18, 2006. Fourth floor rooms 403, 404 and 413 between 9: 11 AM and 11:40 AM in three (3) of seven (7) observations on January 19, 2006. Fifth floor rooms 506 and 517 in two (2) of six (6) observations between 11:44 AM and 12:30 PM on January 19, 2006. 2. Excessive telephone cord and communication wires were observed on floors in ambulating areas of residents' rooms. First floor rooms 102 and 117 in two (2) of nine (9) observations between 3:56 and 4:00 PM on January 17, 2006. Fourth floor rooms 404 and 407 in two (2) of six (6) observations between 9:11 AM and 10:00 AM on January 19, 2006.	L 410	1. Geri-chair armrest in 216, 304, 344, 413, 506, 514 will be replaced. 2. All Geri-chairs were checked and found to be in compliance. 3a. Maintenance Aides will Monitor wheelchairs and Geri-chairs daily for compliance. 3b. Nursing Assistants will be in-serviced to avoid misuse of Geri-chairs when transporting residents. 4. Incidents of torn or worn out Geri-chairs and wheelchairs will be discussed in quarterly QA meeting and reported to the Administrator for repairs or replacement.	3/6/06

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L 410	Continued From page 7 Fifth floor room 517 in one (1) of six (6) observations between 11:44 AM and 12:30 AM on January 19, 2006. 3. Geri chairs armrest in residents' rooms and common areas were torn and damaged in the following areas: Second floor room 216 in one (1) of seven (7) observations at approximately 3:30 PM on January 18, 2006. Third floor rooms 304 and 314 in two (2) of seven (7) observations between 4:45 PM and 5:30 PM on January 19, 2006. Fourth floor room 413 in one (1) of eight (8) observations at approximately 9:15 PM on January 19, 2006. Fifth floor rooms 506, 514 and Social Room in three (3) of seven (7) observations between 11: 44 AM and 12:30 PM on January 19, 2006. 4. Housekeeping closets lacked racks to store mops, brooms and dust pans away from floor surfaces. First Floor in (1) of five (5) observations at approximately 5:10 PM on January 17, 2006. Second Floor in one (1) of five (5) observations at approximately 3:30 PM on January, 2006. Third Floor in one (1) of five (5) observations at approximately 4:20 PM on January 18, 2006. Fourth Floor in one (1) of five (5) observations at 11:25 AM on January 19, 2006.	L 410	1. Closet racks were installed in all janitor closets. 2/10/06. 2. All housekeeping closets needing racks were checked and were found to be in compliance. 2/10/06. 3. All housekeeping closets will be checked during Grand Rounds for compliance regarding closet racks.. 4. The Director of Environmental Services (DES) will submit reports related to problems of closet racks immediately to the Administrator and reports will be presented in quarterly QA meeting.	3/6/06

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L 410	Continued From page 8 Fifth Floor in one (1) of five (5) observations at 12 :10 PM on January 19, 2006.	L 410		