•

1. Charge nurse failed to notify Resident #3's responsible party when he was relocated to another room within the facility. identity other residents who have had a room change. Once identified the family and physicians have been notified A review of Resident #3's clinical record revealed an "Interim Order Form" that indicated "Transfer pt. [patient] to the LL [Lower Level] Unit Rm. [Room] # 076 with medication and all personal belonging" 3. The Social Worker will develop a room change policy. 10/2/08 There was no evidence in the resident's record that the responsible party was informed of the aforementioned resident's transfer order. Initiate the DC 6108 Form for all facility room changes 10/2/08 4 face-to-face interview was conducted on August 5, 2008 at approximately 4:15 PM with Employee #2. He/she acknowledged that the resident's clinical record lacked evidence that the resident's clinical record was Educate the licensed nurse staff on the DC 6108 and the Room Change policy and procedure 10/2/08 ealth Regulation Administration ABORAT/PRTENECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITE POIDATE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD02-0008		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SI COMPLE	
INSCREDUCT AT ROCK CREEK WASHINGTON, DC 20015 If (a) D (a) Comparison of the second of the sec	NAME OF PR			STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•••	
PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY USEC DENTIFYING INFORMATION PREFX TAG PREFX TAG COMPLETE TAG L 000 Initial Comments L 000 Initial Comments L 000 An annual licensure survey was conducted from August 4 through 11, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 15 residents based on a census of 165 the first day of survey. 33 supplemental residents were also included in the survey. 1. #P1 – This resident has never been transferred Based on staff interview and record review for one (1) of 15 sampled residents to another room within the facility, facility staff ailed to notify the responsible party for one (1) resident and the physician for two (2) residents. Resident #3, P1, JH2. 1. #P1 – This resident has never been transferred 1. #J2 – The family was made aware. 1. Charge nurse failed to notify Resident #3's responsible party when he was relocated to another room within the faility. 3. The family was made aware. 10/2/08 A review of Resident #3's clinical record revealed an "Interim Order Form" that indicated "Transfer pt. [patient] to the LL [Lower Level] Unit Rm. [Room] # 076 with medication and all personal belonging" 10/2/08 10/2/08 The rewas no evidence in the resident's transfer order. Poiled and the Room changes 10/2/08 10/2/08 2. A face-to-face interview was conducted on August 5, 2008 at approximately 4.15 PM with Employee 42. Heishe ack	INGLESIE	DE AT ROCK CREEK						
An annual icensure survey was conducted from August 4 through 11, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 15 residents based on a census of 166 the first day of survey. 33 supplemental residents were also included in the survey. Based on staff interview and record review for one (1) of 15 sampled residents and two (2) supplemental residents is to another room within the facility, facility staff failed to notify the responsible party for one (1) resident and the physician for two (2) residents. Resident #3's responsible party when he was relocated to another room within the facility. 1. #P1 – This resident has never been transferred 1. #D1 – This resident has never been transfer 1. #D1 – This resident has never been transfer 1. #D1 – This resident has never been transfer 1. #D1 – This resident has	PREFIX	EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REG	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SH	OULD BE CROSS-	(X5) COMPLETE DATE
		An annual licensur August 4 through 1 deficiencies were b resident interviews size was 15 resident first day of survey also included in the Based on staff inte (1) of 15 sampled r supplemental resid upon relocation of t the facility, facility s responsible party for physician for two (2 JH2. The findings include 1. Charge nurse fait responsible party w room within the fac A review of Reside an "Interim Order F [patient] to the LL [I 076 with medication There was no evide the responsible part aforementioned res A face-to-face inter 5, 2008 at approxin #2. He/she acknow record lacked evide was notified of the a	1, 2008. The following pased on observations, and record review. The ints based on a census 33 supplemental reside e survey. rview and record review residents and two (2) lents, it was determined residents to another roost aff failed to notify the or one (1) resident and 2) residents. Residents e: illed to notify Resident # when he was relocated illity. In and all personal below ence in the resident's re ty was informed of the ident's transfer order. view was conducted or hately 4:15 PM with Em- ledged that the resident ence that the responsib	staff and le sample of 165 the ents were w for one d that om within the #3, P1, 43's to another evealed ransfer pt. [Room] # nging" ecord that	L 000	 never been transf #JH2 – The physimade aware of the transfer #3 – The family waware. Review of the cernidentity other residentity other residentity other residentity and physical develops. The Social Worked develop a room conclust. Initiate the DC 61 for all facility room changes Educate the licent nurse staff on the 6108 and the Roo Change policy and the Roo Change po	erred cian was e as made sus will dents oom entified ysicians d r will hange 08 Form n sed DC	10/2/08 10/2/08 10/2/08
	-		R/SUPPLIER REPRESENTATIVE	S SIGNATURE		G/25/08	 	(X6) DATE

OXJZ11

If continuation sheet 1 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		A. BUILDING		(X3) DATE SU COMPLE	red .
		HFD02-0008	3050 MILI'	RESS, CITY, STA TARY ROAD TON, DC 200	NTE, ZIP CODE	08/1	1/2008
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE(ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLET DATE
L 000	reviewed August 5, 2.Charge nurse faile	-		L 000	The licensed staff wil DC6108, notify the MI and or responsible pa document this informa medical record.	D, Family rty and	ongoir
	A. Review of Reside following nurse's no PM, " Resident mov number]."	3 at 10:00		The room change mu documented on the 24 report.		ongoii	
-	- There was no evide	nce in the record that ed of the resident' s re			 The Social Worker we the census daily for occur room changes and insure completed DC6108. 	rrences of	ongoi
	B. On August 4, 200 stated, " I just move A review of Resider s note dated July 19 [Resident P1] was to to [room number]."	n." I a nurse'		The Social Worker will pr the QA Committee the sy measures put in place to compliance and for QA C recommendations.	stemic insure	9/18/	
	There was no evide physician was notifie A face-to-face interv conducted on Augus stated, "Both reside their families. I didn the physician." The 4, 2008.	relocation. 2 was He/she I notified to notify		The Social Worker will pr monthly findings from the the QA Committee to disc trends and areas of nonc , the effectiveness of the correction and make corr the plan to insure complia	e audit to cuss ompliance plan of ections to	ongoir	
L 001	3200.1 Nursing Faci	lities		L 001		·	
	Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR P 483, Subpart B, Sections 483.1 to 483.75; Sub D, Sections 483.150 to 483.158; and					· ·	

STATE FORM

OXJZ11

If continuation sheet 2 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD02-0008		(X2) MULTIP A. BUILDING B. WING		3) DATE SURVEY COMPLETED 08/11/2008
	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA		00/11/2000
	DE AT ROCK CREEK		3050 MILI	TARY ROAD STON, DC 200	NW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	THE MENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CI REFERENCED TO THE APPROPRIATE DEFIC	
L 001	Continued From page 2 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:			L 001		
L 031	 3207.6 Nursing Facilities The physician shall prescribe a planned remedical care which includes the following (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindication health and safety of the resident; 			L 031	 L031 3207.6 Nursing Facilities 1. Resident #4 A Pain Assessment has been completed and the resident is on routine pai medication. The physician will be notified to address the residents pain in the progress note 2. Resident #P1 The diagnosis of Lipidemia was added to the medica record 9/24/08 	9/24/08
	 health and safety of the resident; (e)Resident therapeutic activities; and (f)Plans for continuing care and discharge This Statute is not met as evidenced by: Based on record review and staff interview (1) of 15 sampled residents and one (1) supplemental resident, it was determined physician failed to: address pain manager one (1) resident and to write an order to in diagnosis of Lipidemia for one (1). Reside 		w for one that the ment for nclude the		2.1 The medical records will b reviewed by the Nurse Manager to determine in any other physicians are out of compliance with addressing pain and insuring appropriate diagnosis are in place. The Manager will notify the MD	,
	 and P1. The findings include: 1. Physician failed to address pain management Resident #4. Physician's Order Sheet (POS) dated February 2 2008 revealed an order for "Propoxyphene 				 The Medical Director wil respond to the facility physician via a letter to inform them about the deficiencies obtained during the survey and remind them of the 	I 10/2/08

MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0008 OF PROVIDER OR SUPPLIER STREET			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
			ADDRESS, CITY, STATE, ZIP CODE					
E AT ROCK CREEK								
(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REG	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE CROSS-	(X5) COMPLETE DATE		
Napsylate W/APAF Darvocet-N 100) 1	2 100mg/650mg tablet ([one] tab by mouth eve		L 031	regulatory standards for pl in long term care.	nysicians			
Record) for March, that the resident re During the month o received Darvocet days and two (2) or (7) of the 20 days.	April and May 2008, re ceived Darvocet almost f March 2008 the reside at least once daily for 2 three (3) times a day fo	vealed t daily. ent 0 of 31 or seven	- -	medical records monthly for residents that have a diagonal pain have a condition that cause pain to insure there plan in place and undated,	or those nosis of may is a care current	ongoir		
received Darvocet a days and two (2) or (7) of 20 days.	at least once daily for 2 three (3) times a day fo	0 of 30 or seven		medical records to insure t	hat all	ongoir		
received Darvocet	26 of 31 days and two (The audits will be turned ir DON monthly	to the	ongoir		
"Duragesic patch 2 (discontinue) Propo A physician's teleph unsigned by the phy	5 mcg q 72 hours. D/C oxyphene." none order dated June ⁻ ysician, directed, "Darv	12, 2008,		be reviewed by the DON/M Director to see which phys out of compliance with mal	ledical ician are king sure	ongoin		
2008, March 18, 20 2008 and June 23, resident's pain statu	08, May 10, 2008, June 2008 but failed to addre us in the progress notes	e 11, ess the		Committee the system changes put in place to	ic o insure	9/18/0		
DON. He/she acknowledged that the physician failed to document on the resident's pain status.								
	E AT ROCK CREEK SUMMARY S (EACH DEFICIENCY MUS OR LSC IE Continued From pa Napsylate W/APAF Darvocet-N 100) 1 hours as needed for A review of the MA Record) for March, that the resident re During the month of received Darvocet days and two (2) or (7) of the 20 days. A review of April's I received Darvocet days and two (2) or (7) of 20 days. A review of May's N received Darvocet days and two (2) or (7) of 20 days. A review of May's N received Darvocet three (3) times a da A physician's order "Duragesic patch 2 (discontinue) Propo A physician's teleph unsigned by the ph N100 1 tab po q 6 h The physician visite 2008 and June 23, resident's pain statu aforementioned dat A face-to-face inter- DON. He/she ackn failed to document of	DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION) Continued From page 3 Napsylate W/APAP 100mg/650mg tablet (Darvocet-N 100) 1 [one] tab by mouth even hours as needed for pain." A review of the MARs (Medication Adminis Record) for March, April and May 2008, re that the resident received Darvocet almost During the month of March 2008 the resider received Darvocet at least once daily for 2 days and two (2) or three (3) times a day fr (7) of the 20 days. A review of April'S MAR revealed that the received Darvocet at least once daily for 2 days and two (2) or three (3) times a day fr (7) of 20 days. A review of May's MAR revealed that the received Darvocet 26 of 31 days and two (three (3) times a day for 10 of 31 days. A physician's order dated June 11, 2008, or "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June unsigned by the physician, directed, "Darw N100 1 tab po q 6 hrs PRM for pain." The physician visited the resident on Febru 2008, March 18, 2008, May 10, 2008, June 2008 and June 23, 2008 but failed to addre resident's pain status in the progress notes aforementioned dates. A face-to-face interview was conducted wit DON. He/she acknowledged that the physian status in the progress notes aforementioned dates.	OVIDER OR SUPPLIER STREET ADD AT ROCK CREEK 3050 MILI WASHING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) OR Continued From page 3 Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet-N 100) 1 [one] tab by mouth every 6 [six] hours as needed for pain." A review of the MARs (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet almost daily. During the month of March 2008 the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. A review of April'S MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. A review of May's MAR revealed that the resident received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. A physician's order dated June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRM for pain." The physician visited the resident on February 26, 2008, March 18, 2008, May 10, 2008, June 11, 2008 and June 23, 2008 but failed to address the resident's pain status in the progress notes for the	OVIDER OR SUPPLIER STREET ADDRESS, CITY, STA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 L 031 Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet-N 100) 1 [one] tab by mouth every 6 [six] hours as needed for pain." L 031 A review of the MARS (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet almost daily. During the month of March 2008 the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. A review of April'S MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. A review of May's MAR revealed that the resident received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. A physician's order dated June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRM for pain." The physician visited the resident on February 26, 2008, March 18, 2008, May 10, 2008, June 11, 2008 and June 23, 2008 but failed to address the resident's pain status in the progress notes for the aforementioned dates. A face-to-face interview was conducted with the DON. He/she acknowledged that the physician failed to document on the resident's pain status.	Divider or Supplier STREET ADDRESS. CITY. STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015 E AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Continued From page 3 Continued From page 3 L 031 Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet-N 100) 1 [one] tab by mouth every 6 [six] hours as needed for pain." L 031 A review of the MARS (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet alleast once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. The Unit Manager will aud medical records to insure there plan in place and undated, and current pain assessmu physician note The veriew of May's MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. The Unit Manager will aud medical records to insure there plan in place and undated, and current pain assessmu physician's dred taded June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." The unitly pharmacy rep be reviewed by the DON// Director to see which phys- out of compliance with mai an appropriate diagnosis is for each medication. 4. The Don will present to committee the system changes put in place to the deficient practice d reoccur. 4. The Don will present to committee the system changes put in place to the deficient practice d reoccur.	DUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015 E AT ROCK CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRECEDED ADDRESS, CITY, STATE, ZIP CODE Continued From page 3 L 031 REFERENCED TO THE APPROPRIATE DEFICIENCY TAG Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet.N 100) 1 (one) Itab by mouth every 6 [six] hours as needed for pain." L 031 A review of the MARS (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. The Unit Manager will audit the medical records to insure there is a care plan in place and undated, current and current pain assessment and physician's order dated June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRM for pain." The unit Manager will audit the medications. The physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRM for pain." The Don will present to the QA Committee the systemic changes put in place to insure the deficient practice does not reoccur. A review of May's MAR revealed that the resident patch 2, 2008, March 18, 2008, May 10, 2008, June 11, 2008, March 18, 2008, May 10, 2008, June 11,		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE HFD02-0008		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		- (X3) DATE SU COMPLE	
NAME OF PF			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			TARY ROAD TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	ULATORY	· ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
L 031	 Continued From page 4 2. The physician failed to write an order to includ the diagnosis of Lipidemia in Resident P1's record On August 4, 2006, at approximately 2:30 PM, during the reconciliation of the medication pass f Resident P1, while reviewing the Pharmacist's "Consultant Report", dated May 1, 2008 the pharmacist recommended to add a diagnosis to justify the use of Omega-3. The Physician signe and dated the response on May 12, 2008 for a diagnosis of Lipidemia. There was no evidence that the physician wrote order to include the diagnosis of Lipidemia or discontinue the Omega-3 in the resident's record A face-to-face interview was conducted on Augu 4, 2008 at 3:00 PM with Employee #12. He/she acknowledged that the physician failed to write th diagnosis. The record was reviewed August 4, 		s record. PM, pass for ist's e sis to signed for a wrote an or record. August e/she write the	L 031	The Don will review th looking for trends and noncompliance. The Committee will discuss and areas of noncom QA Committee will de effectiveness of the p correction and make recommendations for the plan to insure con compliance. L036 3207.11 Nursing 1. The physiciar #4 will be not needs to com H&P for this r 10/2/08 2. All Medical R	d areas of QA so the trends pliance. the etermine the lan of corrections to isistent g Facilities n for resident ified that he iplete a annual resident by	ongoin 10/2/0
L 036	2008. 3207.11 Nursing Fa	acilities		L 036	audited by the insure all resi current annua All physician compliance w that a H & P i	al H & P out of /ill be notified	10/2/0
	examination and ex status at least even documented in the This Statute is not Based on record re	I have a comprehensive valuation of his or her h y twelve (12) months, an resident's medical recor met as evidenced by: view and staff interview	ealth nd rd. for one				ongoin
					The audit will by the Unit M any physician compliance w	anager and out of	ongoin
		nt #4's record revealed a physical evaluation repo			The audit will to the DON.	be submitted	ongoin

STATE FORM

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If continuation sheet 5 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTI A. BUILDING B. WING	PLE CONSTR		(X3) DATE SU COMPLE	
			3050 MILI	RESS, CITY, ST.	NW)E	0011	112000
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L 036			tion had ith kimately bhysical e record e	L 036		The DON will presen systemic changes may the QA Committee to the deficient practice not reoccur. The DON will review audits looking for tren areas of noncomplian The QA Committee v discuss the trends ar of noncompliance. The Committee will detern effectiveness of the pro- correction and make recommendations for changes to the plan to consistent compliance.	ade to insure does the nds and nce. vill ad areas he QA mine the olan of o insure e.	9/18/0
	accuracy in the tran and adherences to s (c)Reviewing reside	scription of physician c	orders,		1.	210.4 Nursing Facilitie Resident JH1 has be discharged and did n her own medication. There are no other re at this time that admi their own medications	en ot give esidents nister	8/6/0
	 (d)Delegating responsibility to the nursing staff direct resident nursing care of specific residents (e)Supervising and evaluating each nursing employee on the unit; and 		dents;		3.	Education the license nurses on the policy a procedure of Self Administration of medications	ed	10/2/08
	her designee inform	tor of Nursing Services ed about the status of net as evidenced by:				An order must be obt from the physician	ained	ongoin
	A. Based on observinterview for one (1)	ations, record review a of supplemental	and staff					

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STATE FORM

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If continuation sheet 6 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER// IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008			
AME OF PF		<u> </u>	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
INGLESI	DE AT ROCK CREEK			ITARY ROAD NW GTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE(ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE		
L 051	L 051 Continued From page 6 resident, it was determined that the charge failed to assess Resident JH1 for the abilit medicate and obtain a physician's order to administer eye drops. The findings include:		ty to self	L 051	The interdisciplinary te assess the Resident fo to administer their own medications and docur findings in the medicat	or the ability n ment	Ongoin		
	A review of Resider following physician	nt JH1's record reveale s orders signed Augus	it 1, 2008:		They must take the Se Administration test and a 100% rate. The test on the medical record.	l pass with will be filed	ongoin		
	" Alphagan P 0.1% drops, Instill [1] drop in each eye twice daily for glaucoma. Betoptic S Droptainer 0.25% drops, instill [1] drop in each eye twice daily for glaucoma. Trusopt Ocumeter Plus 2% drops, instill [1] drop in each eye [3] times a day for glaucoma."				The policy must be rev the Resident and the F must agree to follow th policy	Resident	ongoin		
	during the medicati Employee #10 allow	August 5, 2008, at approximately 8: 15 AM, ng the medication pass for Resident JH1, ployee #10 allowed the resident to self inister the above three (3) prescribed eye			On Admission when ou orders it must be check interim order sheet and must still be followed.	ked on the	ongoin		
	on his/her eyelids, i	esident dropped the m nstead of the in the ey between the administra	es and did		If a resident request to administer after admiss above process must be	sion the e followed.	ongoin		
	Administering Medi conjunction with the	cility's Policy 2.1, "Self cations -(2) The Facilit interdisciplinary team ne, with respect to eac	should		Residents who self adr their own medications on the kardex	it will noted	ongoin		
	resident, whether se safe and appropriat	elf-administration of dru e	ugs is		 Using the 24 h audit the Nurse will audit all ord administration 	e Manager ders for self	ongoin		
;	administration list th resident may self-ad				administration medications The 3-11 supe audit all admis records for ord	rvisor will sion	ongoin		
		resident self-administers his/her ons, the charge nurse, in conjunction			records for ord administration medications.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPI A. BUILDING B. WING		ON	(X3) DATE SURVEY COMPLETED 08/11/2008	
	ROVIDER OR SUPPLIER		3050 MILIT	RESS, CITY, STA	NW			112000
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CO	OVIDER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD BE ED TO THE APPROPRIATE DEF	CROSS-	(X5) COMPLETE DATE
	with the interdiscipli assess the resident ability to carry out the There was no evide Interdisciplinary Ca Resident JH1 was as medications. There administer medication that a routine assess IDT to assess the re- medication. A face-to-face intern 5, 2008 at 9:40 AM stated, "Resident JH medications. [He/s] [his/her] eyelids and eyes. I explained to	L 051	measure deficience The Don looking a compliar discuss t noncomp committe effective correctio recomme	will present systemic made to insure the cy does not reoccur. will review the audits at trends and areas of the trends and areas of bliance. The QA ee will determine the ness of the plan of n and make endations for correctio to insure consistent ice.	e will f	9/18/0 ongoin		
	 unsanitary." The record was review August 2008. B. Based on record review and staff intervien nine (9) of 15 sampled residents and three (supplemental residents, it was determined the charge nurse failed to initiate care plans with appropriate goals and approaches for two (2) residents with Allergies, one (1) resident for Dialysis, one resident for IV (Intravenous) Antibiotics, nine (9) residents for the potentia adverse interaction for the use of nine (9) or medications and one (1) resident for pain an noncompliance with being weighed. Reside 3, 4, 5, 6, 9, 10, 12, 15, F6, JH3 and P1. The findings include: 1. Charge nurse failed to initiate a care plan potential adverse drug reactions for the use (9) or more medications for Resident #1. 		e (3) d that the with o (2) or ntial or more and dents #1,		2.	Care plans for residents 1,3, 4, 5, 9, 10, 12, 15, F6 . JH#. P1 will all be updated The Unit Manager wil audit all Health Cente charts and updated a care plans. Including the deficient care plan 9 or more med, pain care plan, noncompliance, dialysis, allergies . Educate the interdisciplinary team on the care planning	I er II ns	10/2/08

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN		(X3) DATE S COMPL	
		HFD02-0008		B. WING 08/			11/2008
IAME OF PR			STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			TARY ROAD TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ILD BE CROSS-	(X5) COMPLETE DATE
L 051	Continued From pa	age 8		L 051			
	A review of the clinical record for Resident #1 revealed physician orders dated and signed, July and August 1, 2008 that included the following medications: "Ascorbic Acid, Aspirin, Caltrate, Levothyroxine, Metoclopramide, Metoprolol, Multi-Vitamin, Pantoprazole, Zinc Sulfate." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reaction for the use of nine (9) or more medications. On August 5, 2008 at approximately 4:15 PM, a face-to-face interview was conducted with		ned, July 7,				ongoing
			n, : a care		The interdisciplinary Team r weekly to review care plans plans must be updated durir conference insuring an interdisciplinary approach. plan process must include re	the care ng this The care	
			ns. 5 PM, a h	·	and care planning for diagned infections, labs, psych const other MD consult, injuries. Interventions for prevention included.	ults,	ongoing
	lacked a care plan reactions for the us	the acknowledged that for the potential adver se of nine (9) or more ecord was reviewed or	se		 The MDS Coordinator w all care plans due for re the month based on the schedule to insure they 	view for MDS are	ongoing
	potential adverse d (9) or more medica	iled to initiate a care pl Irug reactions for the u tions for Resident #3.	se of nine		complete and up to date audit will be turned in to DON. The MDS Coordinator will pu	the resent to	
	revealed physician 31, 2008 that includ	ical record for Resider orders dated and sign ded the following medi	ed May cations:		the QA Committee systemic put in place to prevent the d from reoccurring and for QA Committee recommendation	eficiency	ongoing
	"Norvasc, Aricept, Namenda, Tamsulosin, Prir Lactulose, Pericolace, Multivitamins, Xalatan, Percocet, and Tylenol.				The MDS Coordinator will put trends and areas of noncom to the QA Committee to disc The QA Committee will disc	ipliance :uss.	
	plan with appropria	ence in the record that te goals and approach ential for adverse drug (9) or more	ies was		trends, areas of noncomplia effectiveness of the plan of correction and make recommendations to the plan insure compliance.		

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If continuation sheet 9 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SU COMPLET	ED		
		HFD02-0008			ESS, CITY, STATE, ZIP CODE		11/2008		
	OVIDER OR SUPPLIER	ζ.	3050 MILITARY ROAD NW WASHINGTON, DC 20015						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLET DATE		
L 051	Continued From particular continued From particular contractions.	age 9		L 051					
	face-to-face interv Employee #1. He/ record lacked a ca reactions for the u	B at approximately 4:15 iew was conducted with /she acknowledged that are plan for the potentia se of nine (9) or more record was reviewed or	n t the I adverse						
	appropriate goals	ailed to develop a care p and approaches for Re- ain medications and for ed to be weighed.	sident #4's						
	resident was admir 2008 with diagnos Syndrome, Lumba Pyelonephritis, Hy	linical record revealed t tted to the facility on Fe es which include Post F Ir Spondylosis, UTI, perkalemia, Hyponatren ttus, Acute Renal Insuff ropathy.	bruary 20, ^p olio mia,		,				
		resident was placed or b PO (by mouth) q 6hrs needed) for pain.							
	Record) for March, resident received I 2008 the resident r	ARs (Medication Admini , April and May reveale Darvocet as follows: for received Darvocet at lea lays and two (2) or three) of the 20 days.	d that the March ast once		•				
	received Darvocet	MAR revealed that the at least once daily for 2 r three (3) times a day	20 of 30						
	A review of May's	MAR revealed that the	resident						

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	egulation Administrat	<u>tion</u>					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SL COMPLE	TÉD
		HFD02-0008				0 <u>8/1</u>	1/2008
	INCLESIOE AT BOCK OBEEK 3050 MIL			RESS, CITY, ST, TARY ROAD TON, DC 20	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETE DATE
L 051	 three (3) times a da On June 11, 2008 a "Duragesic patch 25 Discontinue Darvoc On June 12, 2008, a Darvocet N 100 one The care plan, last n failed to reveal a ca and objectives for p medications. A face-to-face interv Employee #15 on A 9:30 AM. He/she ad lacked a care plan f medications. The re 2008. B. A review of the cl admission note from documented, "Refus diet. Will continue a available." On February 26, 200 "Resident continues The next dietary not documented, "Quart There was no menti this documentation. Review of the nurse 	26 of 31 days and two y for 10 of 31 days. a physician's order dire 5 mg q (every) 72 hrs.	ected, " or pain." 2008, te goals n ith iroximately record pain August 8, an an which n regular ght is nented, 2008 and pleted." eight in 1, 2008	L 051			
Health Regula	tion Administration						

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If continuation sheet 11 of 55

Health R	equlation Administrat	tion							
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SU COMPLE	TED		
		HFD02-0008		08/11/2008					
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA					
	DE AT ROCK CREEK	· · ·		TARY ROAD					
(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 CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPF	IOULD BE CROSS-	(X5) COMPLETE DATE		
L 051	 2008 failed to reappropriate goals arrefusing to be weight A face-to-face intervent Registered Dietician approximately 3:30 the record lacked a weighed. The record 2008. Charge nurse fail potential adverse dr (9) or more medication of the clinic revealed physician of 20, and July 12, 200 medications: "Brimonidine Tartra Ocumeter Plus, Final 	plans last reviewed o veal a care plan with nd objectives for the re	esident's ith the edged that to be gust 5, an for se of nine t #5 ed, June lowing	L 051					
-	plan with appropriate initiated for the pote for the use of nine (\$ On August 5, 2008 a face-to-face intervie Employee #1. He/sh lacked a care plan for reactions for the use	nce in the record that e goals and approach ntial for adverse drug 9) or more medications at approximately 4.15 w was conducted with the acknowledged that or the potential adverse of nine (9) or more cord was reviewed on	es was reactions s. PM, a the record e						
Health Regula	tion Administration								

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If continuation sheet 12 of 55

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Health R	egulation Administrat	ion					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SL COMPLE	
			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		1/2000
	DE AT ROCK CREEK		3050 MILIT	TARY ROAD TON, DC 20	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUI REFERENCED TO THE APPROPRIATI	D BE CROSS-	(X5) COMPLETE DATE
L 051	 appropriate goals ar more medications for The review of the cli revealed a physiciar 10, 2008 that include Amiodipine Besylate D, Catapress-TTS, O Colace, Ferrous Sul Metoprolol, Lopresse A review of the care July 24, 2008 reveal identified and no car appropriate goals an adverse drug interact (9) or more medicati A face-to-face interv Employee #12 on At 10:00 AM. He/she a lacked a care plan for medications. The ref 8, 2008 Charge nurse faile potential adverse dru (9) or more medicati A review of the clinic revealed physician of June 5, and July 10, following medication 	led to develop a care ad approaches for nine or Resident #6. nical record for Resid a's order dated and sig ed the following medic a, Aspirin, and Calcard Certagen, Cymbalta, I fate, Lisinopril, Metola or and Prilosec. plan that was last upp ed that there was no re plan developed with ad approaches for pote tions involving the us ons. iew was conducted w ugust 8, 2008 at appro acknowledged that the or use of nine (9) or m ecord was reviewed or ed to initiate a care pla ug reactions for the us ons for Resident #9. cal record for Resident orders dated and signe 2008 that included th	e (9) or ent #6 gned June cations: b. W/Vit. Digoxin, izone, dated on problem n ential e of nine ith bximately e record ore n August an for se of nine t #9 ed, May 9, ie	L 051			
	tion Administration	· · · · · · · · · · · · · · · · · · ·					

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Health R	egulation Administra	tion					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		HFD02-0008		B. WING		. 08/1	1/2008
NAME OF PF			STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
INGLESI				TARY ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	I SHOULD BE CROSS-	(X5) COMPLETE DATE
L 051	Continued From pa	ge 13		L 051			
	plan with appropriat initiated for the pote for the use of nine (On August 6, 2008 face-to-face intervie Employee #1. He/sl lacked a care plan f reactions for the use medications. The re 2008.	ance in the record that the goals and approach ential for adverse drug 9) or more medications at approximately 5:05 we was conducted with the acknowledged that or the potential adverse of nine (9) or more cord was reviewed on	es was reactions s. PM, a the record se August 6,				
	potential adverse dr	ed to initiate a care pla rug reactions for the us ions and dialysis for R	se of nine				
	potential adverse di	led to initiate a care pla rug reactions for the us ions for Resident #10.	se of nine				
	revealed a physicial 1, 2008 that include Amiodarone, Aricep	linical record for Resid n's order dated and sig d the following medica t, Allegra, Flomax, Las e, Inderal, Rena-Vite, S	ined July itions: six,				
	30,2008, revealed the identified and no car appropriate goals and so the second	plan, last updated on nat there was no probl re plan developed with nd approaches for pote ctions involving the use ions.	em I ential				
		view was conducted wi oproximately 10:00 AN					
Health Regula	tion Administration						

Health R	Regulation Administrat	tion					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		A. BUILDING		(X3) DATE SU COMPLE	
		HFD02-0008		B. WING		08/1	1/2008
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			TARY ROAD TON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
L 051	Continued From page	ge 14		Ŀ 051	,		
	record lacked a care	she acknowledged the plan for use of nine (ecord was reviewed or	9) or more				
		iled to develop a care nd approaches for Dia				·	
	revealed that the res facility on March 24, ESRD (End Stage F	cal record for the resic sident was admitted to 2008 with diagnoses Renal Disease) and a recting, "Dialysis M, W iday."	the including				
	A review of the care with goals and appro	plans revealed no ca oaches for dialysis.	re plan				
	Employee #12 on A 10:00 AM. He/she a	view was conducted w ugust 8, 2008 at appro acknowledged that the or dialysis. The record 8, 2008.	ximately record				
	potential adverse dr	ed to initiate a care pla ug reactions for the us ions for Resident #12.	se of nine				
	revealed a physiciar 25, 2008 that includ Rocaltrol, Cardizem Clonidine, Nystatin S	nical record for Resid n's order dated and sig ed the following medic , Prograf, Bactrim SS, Swish & Swallow, Stre ednisone and Keppra.	ned July ations: Valcyte,				
		plan, last updated on there was no care pla opriate goals and					
Health Regula	tion Administration	·					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SU COMPLE	TED
		HFD02-0008	<u> </u>		r	08/1	1/2008
NAME OF PF	OVIDER OR SUPPLIER	,		RESS, CITY, STA			
INGLESI	DE AT ROCK CREEK			TARY ROAD I TON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE INTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETE DATE
L 051	Continued From pag approaches for pote involving use of nine A face-to-face interv Employee #12 on At 10:00 AM. He/she a lacked a care plan for medications. The re 8, 2008. 9. Charge nurse fail potential adverse dr (9) or more medicati A. Review of the clirr revealed physician of 2008 that included th "CalciumCarb-VitD, Advair, Neutrontin, C Dilaudid, Klor-Con, F There was no evider plan with appropriate initiated for the poter for the use of nine (S On August 8, 2008 a face-to-face interview Employee #2. He/sh lacked a care plan for reactions for the use	ge 15 ential adverse drug inte e (9) or more medicati view was conducted w ugust 8, 2008 at appre acknowledged that the or use of nine (9) or m ecord was reviewed of ed to initiate a care plug reactions for the us ions for Resident #15. hical record for Reside orders dated and sign he following medication Benadryl, Ferrous Su Dxycontin, Senna S, E Prilosec, and Cefepim nece in the record that e goals and approach ntial for adverse drug 0) or more medication at approximately 9:10 w was conducted with e acknowledged that or the potential adverse	ons. vith oximately e record nore n August an for se of nine ent #15 ed June ons: ulfate, Dyaziade, ie." a care es was reactions s. AM, a the record se	L 051			
		led to develop a care ergies.	plan for				
lealth Regula	tion Administration		I				

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Health R	egulation Administrat	tion	_				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLET	ED
		HFD02-0008				08/1	1/2008
	ROVIDER OR SUPPLIER		3050 MILI	DRESS, CITY, STA TARY ROAD TON, DC 20	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE(ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	I SHOULD BE CROSS-	(X5) COMPLETE DATE
L 051	Care" dated Februa physician on Februa cephalosporins, cod " A review of the care 2008 lacked evidend was developed with address the residen codeine, penicillins A face-to-face interv 8, 2008 at 9:30 AM He/she acknowledg F6's allergies was d reviewed on August 11. Charge nurse fa adverse drug interac more medications for A review of Residen physician's order fro included 11 medicat were ordered: "Ascorbic Acid 500 r Folic Acid 1 mg table Capsule, Metoprolol vitamin table, Polyet Simvastin 20 mg tab Milk of magnesium 4 and Oxycodone IR 5	vsician Order Sheet ar ry 21, 2008 and signe ary 29, 2008 revealed, leine, penicillins and to e plans last updated or ce that a care plan for goals and approache t's allergies to cephalo and tramadol. view was conducted of with Employee #Ange ed that a care plan for eveloped. The record 8, 2008. illed to initiate a care p ctions for the use of ni or Resident JH3. tt JH3's record revealed m signed July 19, 200 ions. The following me mg tablet, Diovan 160 et, Gabapentin 300 mg Succinate 50 mg tabl hylene glycol 100% p olet, Thiamine100 mg 400 mg/5 ml oral susp	d by the "Allergies ramadol n June 30, allergies s to osporins, n August la. Resident was olan for ne (9) or ed a 08, edications mg tablet, g et , Multi- owder, tablet, ension	L 051			
Health Regula	tion Administration		_				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD02-0008		A. BUILDING	LE CONSTRUCTION	(X3) DATE SI COMPLE	
				 RESS, CITY, STA		00/	1/2000
	ROVIDER OR SUPPLIER		3050 MILIT	TARY ROAD	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETE DATE
L 051	JH3 for adverse dru (9) or more medicat record was reviewed 12. The charge nurs for adverse drug into or more medications A review of Resider physician's order sig the following 11 rou "Atenolol 25 mg tab capsule, Gabapentin patch, Meloxicam 7. Omega-3 softgell 10 ER 5mg tablet, Sert mg tablet, Systane 0 Warfarin 1 mg tablet Warfarin 4 mg tablet Warfarin 4 mg tablet A face-to-face interv Employee #12 on A He/she acknowledg interactions for the 0 medications was no record was reviewed C. Based on observ interview for one (1) was determined that Resident JH1 for the	Ig interactions for the tions was not initiated. d 4, 2008. se failed to initiate a c eractions for the use of s for Resident P1. Int P1's record revealed gned July 2, 2008 that tine medications: let, Docusate sodium n 100 mg capsule, Lic .5 mg tablet, Multi-vita 200mg capsule, Oxyb raline 25 mg tablet, S 0.3% - 0.4% ophthalm t, Warfarin 2.5 mg tablet, S 0.3% - 0.4% ophthalm t, Warfarin 2.5 mg tablet, t." view was conducted w ugust 4, 2008 at 3:10 ed a care plan for adv use of nine (9) or more t initiated for Residen d August 4, 2008. rations, record review of supplemental resid t facility staff failed to e ability to self medica order to self administ	The are plan of nine (9) d a t included 100 mg doderm 5% umin tablet, utynin Cl sertaline 50 nic drop, olet, and with PM. verse drug e t P1. The and staff dent, it assess ite and	L 051	C 1 The resident is no lo her own eye drops. 2. There are no other re this time that administer to medications 3. Educate the licensed of the policy and procedure Administration of Medicate An order must be obtained MD The interdisciplinary team assess the Resident for to Administer their own med The Resident must take at Self Administration of Me pass with a 100% rate. To must be filed on the med The policy must be review Resident and the Resider agree to follow the facility If a resident request to se administer after admissio must be obtained. The For must be assessed, tested review, and agree to follo Administration policy. Pla Resident on the 224 hour in the Supervisors Book.	esidents at heir own nurses on of Self tions. ed from the must he ability to lications. a test for ds. and he test ical record. wed with the n must policy. If n an order Resident I, policy w the Self ace the	8/5/08 8/5/08 10/2/08 ongoing ongoing ongoing ongoing
		t JH1's record reveale s orders signed Augus			The Resident must be ev quarterly and if there is a condition.		ongoing

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE HFD02-0008				(X3) DATE SURVEY COMPLETED 08/11/2008		
			3050 MILIT	DDRESS, CITY, STATE, ZIP CODE LITARY ROAD NW NGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETE DATE	
L 051	2008: " Alphagan P 0.1% twice daily for glaud Betoptic S Droptain each eye twice dail Trusopt Ocumeter F each eye [3] times a On August 5, 2008,	drops, Instill [1] drop in coma. ler 0.25% drops, instill [y for glaucoma. Plus 2% drops, instill [1] a day for glaucoma." at approximately 8: 15	1] drop in] drop in AM,	L 051	 The Unit Manager usin 24 hour chart audit will monitor self administra of medications The 3-11 Supervisor will audits for orders for self administration The Don will present syste measures made to insure to 	tion udit on mic he	ongoin ongoing 9/18/08	
	 On August 5, 2008, at approximately 8: 15 AM, during the medication pass for Resident JH1, Employee #10 allowed the resident to self administer the above three (3) prescribed eye medications. The resident dropped the medication on his/her eyelids, instead of the in the eyes and did not wait 5 minutes between the administration of the other eye drops. According to the facility's Policy 2.1, "Self Administering Medications -(2) The Facility, in conjunction with the interdisciplinary team, should assess and determine, with respect to each resident, whether self-administration of drugs is 		eye edication is and did tion of the , in should n		deficiency does not reocce and for recommendations of the QA Committee The DON will review trends areas of noncompliance. T QA committee will discuss the trends and areas of non compliance and make recommendations for the p of correction to insure consistent compliance.	rom s and he the n	ongoin	
	administration list th resident may self-ad	nsure that orders for se le specific medication (s dminister				·	1	
	medications, the Fa interdisciplinary tear	elf-administers his/her cility, in conjunction wit m, should routinely asso physical and visual abi nsibility"	ess the					
	Interdisciplinary Car Resident JH1 was s medications. There	nce in the record that the e Team (IDT) determin afe for self administration was no physician's orde ons. The record lacked	ed that on of					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD02-0008	CLIA BER:	(X2) MULTIP A. BUILDING B. WING		(X3) DATE SU COMPLE		
				RESS, CITY, STA		00/1	1/2008	
			3050 MILIT	NGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE	
L 051	Continued From page	ge 19		L 051	· · · · · ·			
		ine assessment was on the resident's ability						
	5, 2008 at 9:40 AM stated, "Resident JH medications. [He/sh [his/her] eyelids and eyes. I explained to	view was conducted o with Employee #10. H 11 wants to give [him/l he] wants to put drops I let the fluid drop in [h b [Resident JH1] that ecord was review Augo	He/she her] own on iis/her] it was					
L 052	3211.1 Nursing Fac	ilities		L 052				
	Sufficient nursing tin resident to ensure th receives the followin		ach					
		cations, diet and nutriti ids as prescribed, and g care as needed;						
		nimize pressure ulcer promote the healing o						
	resident is comfortal evidenced by freedo	y personal grooming s ble, clean, and neat as om from body odor, cle clean, neat and well-gr	s eaned and					
	(d) Protection from a	accident, injury, and in	fection;					
	(e)Encouragement, a care and group activ	assistance, and trainir rities;	ng in self-					
	(f)Encouragement a	nd assistance to:						
	(1)Get out of the bec	d and dress or be dres	sed in					
Health Regula	tion Administration							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULTIPI A. BUILDING B. WING		(X3) DATE S COMPL				
			STREET ADD	REET ADDRESS, CITY, STATE, ZIP CODE						
	DE AT ROCK CREEK		3050 MILIT	ITARY ROAD NW GTON, DC 20015						
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L 052	 ² Continued From page 20 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, 		L 052	 Resident #2, a given incontin the splint was All residents w checked to ins continence ca on 8/6 and 8/7 Incontinent Ro done every 2 nursing assist on the nursing rounds sheet given incontin rounds sheets each residents 	ent care and washed vill be sure re was given 7. ounds will be hour. The ants will initial g assistant that they have ent care. The s will be in	8/6,7 ongoing				
	including oral acre; j)Prompt response help.	and to an activated call bell			The licensed s check the nur rounds sheets document on t incontinent ca given.	rsing assistant daily and the TAR that	ongoing			
	 This Statute is not met as evidenced by: A. Based on an observation, staff interview and record review for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff neglected to provide appropriate and timely care for (1) resident wearing a soiled hand splint and incontinent care for three (3) residents. Residents # 2, and A3. 1. Nursing staff failed to provide incontinent care to Resident #2 in a timely manner and change a soiled hand splint. During an observation of the Day Room/Activity Area on August 6, 2008 at 10:25 AM, Resident #2 was observed sitting in his/her wheel chair. The resident emanated a strong odor of urine. The resident was wearing a hand splint which was observed to be soiled with accumulated food 		esidents provide it wearing		The Unit Mana review the nur list weekly and the DON. 4. The Don will p	sing rounds I submit to resent the	ongoin <u>(</u> 9/18/08			
					systemic chan insure the defi does not reocc QA recommer	cient practice cur and for				
				• The DON will audits looking		ongoing				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SI COMPLE		
			3050 MILI	ADDRESS, CITY, STATE, ZIP CODE IILITARY ROAD NW NGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE	
L 052	stuffs. At 10:10 AM on Aug taken over to the res resident needed to be needed to be cleane Employee #3 respon CNA (Certified Nurs [him/her]." Employe five (5) minutes later [He/she] is taking ca come as soon as [he At 10:50 AM, 40 min returned and stated [He/She] is still with [him/her] to come ar when [he/she] is finit At 11:20 AM Employ resident and procee room. When asked w resident, the employ change [him/her]." At 11:35 AM, Employ back into the day roo wearing the soiled s whether Employee # the soiled hand splin added "That looks lift night, macaroni and have another one to washed.". The recor 2008. 3. Nursing staff failed care for Resident A3	just 6, 2008, Employed sident. He was told th be changed and that th ed. ing Aide) to take care ee #3 returned approx r and stated "I told the are of another resident e/she] is finished." nutes later Employee # "I went to check on th the other resident. I m d take care of this resished over the ded to wheel him/her to where he/she was taking ee responded, "I am g yee #8 wheeled the re- om. The resident was plint. The employee w 3 had asked him/her to the stuff from dinne cheese. If I take it off put on and it has to be d was reviewed August	at the ne splint signed of imately e CNA. and will a 3 ne CNA. eminded sident the but of the ng the going to esident still vas asked to clean "No" and r last , I don't est 6, ontinence	L 052	and areas of noncomp The trends and areas noncompliance will be by the QA Committee Committee will detern effectiveness of the pl correction and make recommendations to t insure consistent com splint There are no other res house with a splint Develop a policy and for splint care Educate the nursing s regarding splint care	of discussed The QA nine the an of he plan to pliance.	8/6/08 10/2/08 10/2/08	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 			
	ROVIDER OR SUPPLIER	STREET ADDF 3050 MILIT	DDRESS, CITY, STATE, ZIP CODE LITARY ROAD NW GTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE AC	N OF CORRECTION (X: CTION SHOULD BE CROSS- COMP PPROPRIATE DEFICIENCY) DA			
· L 052	in the day room on approximately 12:30 wet with a strong ur thighs to the waist. Approaches and int Care Plan" [related dated June 30, 200 (2) hours and as ne incontinent episode after each episode after	August 7, 2008. At 0 PM, the resident was observed ine odor bilaterally from the rervention for an "Incontinence 1 to recent decreased mobility] 8 indicated: "Toilet every two reded to decrease number of is. Keep resident dry, especially of incontinence." view was conducted with ugust 7, 2008 at approximately said, "I am taking the resident om now to provide incontinence 10 acknowledged that the ovided incontinent care in the sakfast at approximately 8:30 is reviewed on August 7, 2008. vation, record review and staff of 15 sampled residents and al resident, it was determined ed to: follow physician's orders d splint for one (1) resident and arm for one (1) resident. F4. ailed to follow a physician's int for Resident #2. cal record revealed an x-ray 8 with the impression, "Fracture fth metacarpal."	discontinu compliance #2 2. Resident a was replat Facility failed f management 2, The Unit massess all resis potential for pathere is curre assessment Facility failed f bed/chair alart The Unit mana will audit all resishould have a and insure an place 3. Educate th on the pai policy and The licens audit ever and chair resident a placement Pain Mana The Unit mana place and	the splint to be ued due to non ce for resident #F4 bed alarm ce. to address pain hanager will idents with the ain and insure nt pain to apply m ager /designee sidents that bed/chair alarm alarm is in he nursing staff in management l procedure. Sed nurse will y shift the bed alarms for each nd document t on the TAR.			

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ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING B. WING		3) DATE SURVEY COMPLETED 08/11/2008			
	ROVIDER OR SUPPLIER DE AT ROCK CREEK		3050 MILIT	REET ADDRESS, CITY, STATE, ZIP CODE 50 MILITARY ROAD NW ASHINGTON, DC 20015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRIATE DEFIC	ROSS- COMPLETE			
L 052	spiral fracture of the A Report of Consul specialist dated Jul removed Wear p weeks. Follow up p On August 4, 2008 11:00 AM to 12:30 PM, Resident # 2 v splint on his/her rig On August 5, 2008 12:00 PM the reside the hand splint. On August 6, 2008 observed seated in wearing a soiled ha A face-to-face inter Employee #13 on A He/she acknowledg wearing a splint at f "[He/she] keeps rer doctor and let [him/ reviewed on Augus 2. Charge nurse fa Resident F4 as per A review of the phy February 2008 dire- while in bed and our as conducted. The	e distal ulna." Itation from an orthoped ly 31, 2008, documente protective splint for three prn (as needed)." at approximately 9:30 AM and from 2:30 PM was observed without t ht arm. from 10:00 AM to appr ent was again observe at 10:25 AM Resident a wheel chair in the da and splint on the right a view was conducted w August 4, 2008 at 3:20 ged that the resident wa that time. He/she adde moving the splint. I will /her] know." The record at 4, 2008. illed to apply a bed/cha the physician's order. rsician's order sign and cted, "Personal [name] at of bed in chair for saf	ed, "Cast ee (3) AM, from to 3:20 he hand roximately d without #2 was ay room rm. ith PM. as not ed call the d was ir alarm to not dated alarm ety." chair	L 052	The pain audit and the alarm audit will be turned into the DON. 4. The DON will present the systemic measures put in place to insure the deficiencies do not reoccur and for QA committee recommendations. The DON will review all audits looking for trends and noncompliance areas. The QA committee will discuss the trends, noncompliance areas, and the effectiveness of the plan of correction. Make corrections and recommendations to the plan to insure consistent compliance.	ongoing 9/18/0			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING B. WING		(X3) DATE SU COMPLET	
				RESS, CITY, STATE		00/1	1/2000
	ROVIDER OR SUPPLIER		3050 MİLI	TARY ROAD N TON, DC 2001	w	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
L 052	 8, 2008 at 7:44 AM acknowledged that if not on the resident's The record was revi C. Based on observitive (2) of # 2 dressing that proper infection followed to prevent in treatments. Resident The findings included On August 5, 2008 apressure ulcer treatment. A physician's teleph 2008, directed, "Clecleanser, pat dry, apressure with Allevyn didays." Employee #11 enter container filled with the completion of dressing was discare closed, removed from placed in a biohazar room. Employee #11 failed 	view was conducted or with Employee # 11. I the bed and/or chair al s wheel chair or in the ewed on August 8, 20 vations and staff interving changes, it was de control procedures w infection during pressunts #1 and 6.	He/she arm was room. 08. iew for termined ere not ure ulcer 0 PM a r Resident st 4, h wound t and uate in 14 n with a or all the resident. led nich was and r utility s in the	L 052	 Resident #1 and # nurses were educe on infection control practices for dress change and prope of treatment produ All residents who h wounds have the potential to be affe by the deficient pro- Each nurse having resident with a wo was observed doir dressing change All licensed staff w required to pass a competency for dr change yearly and needed as issues The current licenses staff will be monito the next 30 days for compliance with infection control ar dressing change process by the Sta Development Coordinator./desig The competency w the tool used to me the nurses strengtli weaknesses in the infection control pro- 	ated ated	
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTII A. BUILDING B. WING	G	(X3) DATE SU COMPLET	ſED
		HFD02-0008	1			08/1	1/2008
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
INGLESI				TARY ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
L 052	Continued From page	ge 26		L 052			
	alasity sis/each itanfi(sout the ascuircation because the theatment base bet/atabittgemeen bood from Resident #1's room and returned to the supply room. D. Based on observations and staff interview for				Treatment Carts will purchase to insure each resident has their own labeled supplies		8/30/08
	2. Dased on observations and stan merview for Awfa(2) tof #a@ediretssingvcharsgesnituvtes/date/wigued In 2000 patrappeokion adentrol1pf & dadwittesEmapteopee followites/sopeowerowinfedgiesh dsimiogroporsgate(wtoend traathreatmeRtesideliotstikth) aladbeled for another resident's use, failing to wash his/her hands				Newly hired employees will hav to pass a infection control competency that will include dressing change.	e	ongoing
	innerediatelys after de containing the soile end Augustan 2002 proused reacted project resident's room. He	scarding the trash bag d dressing from Resid at ອຸຊາວວາກຳສະເອກາອາ ຄາຍກິດພາສາດປະອາດີນອີດ /she said, "We will pu	g ent #1, orrtøining Mi Rossident irchase		The Staffing Coordinator will educate all nursing staff on the infection control process. 4. The DON will present to the		10/2/08
	Agnyawan's "teleph 2008, directed, "Cle 2leansergost Gry209	sident's wound care su one order dated Augu anse sacral wound wi boot and work and w	ist 4, th wound it5aAdM a		 The DON will present to the QA committee the systemic measure put in place to insure that the deficient practice does not reoccur and for recommendations. 		9/18/08
· · ·	begianiegfihecoware essiberts text is inter- two pieces of paper intervolvely promused reaganent the tablet reaganent the tablet dressing was discar bloesc, or pieces intervol placed the bag not placed the bag and placed	ned Ristingenhample prior detendent and supplies tower from the tower physical care to an and physical supplies and a plastic bag w there as a detend to an a supplier of the application of the table. The employee r it in the soiled utility ro type bass table, nation and the went around the physical supplication of the supplies and added, "	Roseal/The oyee tore dispenser oyeces of geothorose iled which was natoyee yeutility emoved yeutility emoved bom but year the unit to inth the wassteent wassteent		The Staff Development Coordinator will bring to the QA Committee evidence for the 30 day competency review for the licensed nurses, the quarterly competency review and evidence of the orientation competency for new employees The QA committee will discuss areas of noncompliance, the effectiveness of the plan of correction make recommendations and corrections to the plan of correction as needed.		ongoing
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		(X2) MULTIPL A. BUILDING B. WING		(X3) DATE SU COMPLE	
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	NAME OF PROVIDER OR SUPPLIER			ARY ROAD I	W		
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L 052	 7, 2008 at approxim #11. He/she acknow care treatment med resident's use, failin immediately after di containing the soile and using and failed wound care supplie resident's room. He baskets for each res from now on." 2. On August 6, 200 dressing change wa right heel, left heel a Employee #14 wash beginning the proce over bed table prior two pieces of paper in the bathroom. He paper on the table a supplies on top of the Upon completion of 	view was conducted or hately 1:15 PM with Em wledged: using hydroge ication) labeled for and g to wash his/her hand scarding the trash bag d dressing from Reside d to clean the carrier co s after removing it from /she said, "We will put sident's wound care su 08 at approximately 9:1 as observed on Reside and right shin. hed his/her hands prior edure but failed to clear to using it. The employ towel from the towel d e/she placed the two pland placed the dressing	ployee el (wound other ds ent #1, ontaining n the chase pplies 5 AM a nt #6's to nse the yee tore ispenser ecces of g change	L 052			
	resident's over bed the bag and placed	table. The employee re it in the soiled utility ro ver bed table after its u	emoved om but				
	employee at approx 2008. He/she ackno clean the table after	view was conducted wi imately 9:45 AM on Au owledged that he/she o using it and added, " s nervous because I kr	igust 6, lid not I always				
	E. Based on observ	vations, record review a	and				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SU COMPLET	ED			
		HFD02-0008		ET ADDRESS, CITY, STATE, ZIP CODE						
	OVIDER OR SUPPLIER		3050 MILI	IILITARY ROAD NW NGTON, DC 20015						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE			
L 052	and one (1) suppler determined that faci appropriate treatme #2 and A3. The findings include 1. Nursing staff faile Resident #2 in a tim During an observati Area on August 6, 2 was observed sitting resident emanated a At 10:10 AM on Aug taken over to the res resident needed to b needed to be cleane Employee #3 respon CNA (Certified Nurs [him/her]." Employ five (5) minutes late [He/she] is taking ca come as soon as [hi At 10:50 AM, 40 min returned and stated [He/She] is still with [him/her] to come ar when [he/she] is fini At 11:20 AM Employ resident and procee room. When asked or resident, the employ change [him/her]."	ne (1) of 15 sampled re nental resident, it was lity staff failed to provi nt for incontinence. Re et d to provide incontine nely manner. on of the Day Room/A 008 at 10:25 AM, Res g in his/her wheel chai a strong odor of urine. gust 6, 2008, Employe sident. He was told th be changed and that the hed "I will get the as ing Aide) to take care ee #3 returned approx r and stated "I told the are of another resident e/she] is finished." nutes later Employee # "I went to check on the the other resident. I m take care of this res	de esidents nt care to .ctivity ident #2 r. The e #3 was at the ne splint signed of imately e CNA. and will # 3 ne CNA. eminded sident o the out of the going to	L 052						
Health Regula	tion Administration									

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SU COMPLE	TED		
						08/1	1/2008		
	OVIDER OR SUPPLIER		3050 MILIT	ADDRESS, CITY, STATE, ZIP CODE IILITARY ROAD NW NGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE ACTIO REFERENCED TO THE APPF	N SHOULD BE CROSS-	(X5) COMPLET DATE		
L 052	back into the day ro August 6, 2008. 2. Nursing staff faile care for Resident A The resident was of the day room on Au 12:30 PM, the resid strong urine odor bi waist. Approaches and int Care Plan" [related dated June 30, 2006 (2) hours and as ne incontinent episode after each episode of A face-to-face interv Employee#10 on Au	oom. The record was re ed to provide timely inco 3. bserved seated in whee gust 7, 2008. At appro ent was observed wet v laterally from the thighs ervention for an "Inconf to recent decreased m 8 indicated: "Toilet eve eded to decrease numl s. Keep resident dry, es	entinence elchair in iximately with a s to the tinence iobility] ery two ber of specially	L 052	 The main kitcl was emptied. The trash was around the tra compactor All trash recept checked to ins were not over had a lid on to The kitchen stand add to the dait check trash ret to insure the t properly dispose Educate the k on the propert garbage and ret 	s removed ash otacles were sure they flowing and op upervisor will ly kitchen eceptacles rash is osed of. itchen staff disposal of refuse.			
	back to [his/her] roo care." Employee #1 resident was last pr morning, before bre AM. The record was	om now to provide incor 10 acknowledged that to ovided incontinent care akfast at approximately s reviewed on August 7	htinence he in the v 8:30	- 400	daily check th to insure the t the compactor up. 4. The Superviso kitchen and M will present to Committee the changes made	rash a round r is picked ors for the laintenance the QA e systemic			
L 106	3219.8 Nursing Facilities Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to dispose of food			L 106	the deficient p not reoccur. The Supervise present finding audits looking areas of nonce The	ractice does ors will gs of the at trend and			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING		(X3) DATE SUF COMPLET				
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NAME OF PR		· · ·	STREET ADD	DRESS, CITY, STATE, ZIP CODE						
INGLESI	DE AT ROCK CREEK			TARY ROAD TON, DC 20						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE(ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD F REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE			
L 106	The findings include A tour of the main ki 4, 2008 between 8.4 staff was observed of waste in a trash rect that food, paper and in the same trash rec Employee #27 ackn the time of the obse were two (2) working kitchen. 3227.12 Nursing Fa Each expired medic usage. This Statute is not r Based on observation medication rooms, a determined that the expired medication f medications, replaced initial four (4) of seven vials when first oper The findings include 1. The charge nurse medication cart. Facility's policy 5.3, Dating of Drugs, Bio	e: itchen was conducted 45 AM and 12:00 PM, disposing of food and eptacle. It was further a metal waste were dis- icceptacles. owledged the above find rvation and stated that g garbage disposals in cilities ation shall be removed met as evidenced by: on of two (2) of three and staff interview it w facility staff failed to reform currently dated e emergency box and en (7) multi-dose med ned. e failed the remove exprently dated medication in medication rooms an Sec. 3, "Storage and logicals, Syringes and cility should ensure that	dietary paper r observed sposed of indings at t there n the d from (3) /as emove date and ication oired on from the Interim d a Expiration	L 106	 QA Committee will make recommendations for corrections to the plan of correction. Expired meds All expired pharmacy boxes and medications were removed from the Medication Rooms. All interim boxes were removed from the Health Center. The only box remaining is the Emergency Box which ahs to remain due to regulations. All med rooms and med carts were checked to insure there were no expired or discharge meds in the carts. In discussion with the pharmacy we will no longer be using the interim boxes due to in inhouse Omnicell. 					
Health Regula	tion Administration									

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD02-0008		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/11/2008			
AME OF P			STREET ADDRESS, CITY, STATE, ZIP CODE						
INGLESI	DE AT ROCK CREEP	ζ (3050 MILITARY ROAD NW WASHINGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REC DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	ORRECTION HOULD BE CROSS- RIATE DEFICIENCY)	(X5) COMPLET DATE			
L 161	expired date on the from other medica to the supplier." On August 6, 2000 AM, the facility's m included the IV Inf Oral/Injection Inte cabinets, the med inspected on each A. The IV Infusion January 2008 was box was located in Upon opening the injections and IV ff Quantity Desc Expiration Dat 1 Methyl pre 1/2008 4 Nafcillin 1 2 Sterile Va 7/1/2008 3 Clindamy 11/1/2007 2 Sterile Wa 6/162008 3 Unasyn 1 4/1/2007 3 Zosyn 2.2 5/2008 (2) 2 Tazicef 1	e label: are stored se tions until destroyed or 8, between 8:15 AM and hedication storage areas erim Infusion box, the im Box, medication root ication refrigerator and o unit. Interim box's expiration on the outside of the bo in the upper level medica interim box the following uids were found expired ription te ednisone 125 mg vial gm vial ncomycin 1 gm vial cin 900mg/6 ml vial ater 20 ml Vial Sublactam 1.5 gm vial .5 gm vial /2007 (2) zine 50 mg/ml vial 5 gm vial	returned I 11:30 s, which m carts were I date of ox. The ition room. g 1: 1/2008	L 161	 The Omnicell will be up contain the same medic that were in the interim narcotic. Al list of medications is near the Omnicell All licensed staff will ed how to use the Omnicel All licensed staff will be on dating open vials, redischarge med, 5 rights medication administratiproper handling of expire All nurses will be educat check every shift for expired initialing when a new visiopened. The 11-7 charge nurses unit will be responsible checking the med carts med rooms for expired medications and disposithem. The 11-7 Supervisor wir random weekly audit of med cart and med room insure that there are no meds on the cart or in the room, audit for unlabele that have been opened initialed. 	cations boxes box. posted ucated on ucated on ucated on ueducated turning of on, red meds, ted to pired ig and al is s on each for and the ing of ill do a each to expired he med d vials			

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TATEMEN ⁻ ND PLAN (D PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008	
NOLESIDE AT POCK CREEK 3050 MIL			3050 MILI1	RESS, CITY, STA FARY ROAD TON, DC 20	NW		1/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETE DATE
L 161	 18 0.9% NaC 6/2008, 5/2008 5 0.9% NaC 12/2007, 1/200 1 10% Dextr 7/2008 1 5% Dextro 1 KCI 20 mE 3/2008 B. The following ex the upper level cab 2 Glutose 15 4/2008 25 Duo neb lp 5/2008 100 Saline flus 1/11/2008 The following media level medication ca 2 Lorazepan 8/3/2008 C. The inspection of the lower level, incl box. The box's expi was located on the opening the Interim were expired: Amoxicillin 250 mg November, 2007 Duricef 500 mg, 6 c 	1 5 ml filled syringes 1 100 ml IV bags 1 100 ml IV bags 1 100 ml IV bags 1 100 ml IV bag 1 100 ml IV bag 2 1000 m	Sulfate lower le area on interim er 2007 on ications	L 161	 The Consultant Pharmacis continue to inspect the metrooms monthly and report a expired medications and unlabeled meds and assist noting that the Emergency has not expired and call the pharmacy for pick up. The med rooms and the metcarts will be apart of the nursing weekly rounds with DON , Unit manager, nursil assistant and the charge new Weekly time 60 days there once a month. The Don will present the systemic changes mad insure the deficient pradoes not reoccur. The Don will review the audits looking at the trea and areas of noncompliance. The trand the areas of noncompliance will be discussed by the QA Committee will determing the effectiveness of the plan of correction make recommendations for corrections to the plan insure consistent compliance. 	d any in box e ed the ng urse n e e to ctice ends ends ends	

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Health R	egulation Administration	tion					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SL COMPLE	TED
		HFD02-0008				08/11/2008	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
	DE AT ROCK CREEK		-	TARY ROAD			
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L 161	2008 Clonidine 0.1 mg, 1 through March, 200 Aspirin 325 mg, 13 th November 2007 and Nitrofuranton 50 mg February and June, Lasix 20 mg, 6 of 12 2007. Employees #14 and inspection of the me acknowledged the e of the above cited o A face-to face interv 6, 2008, at approxin #16. He/she stated have been returned automated dispensi 2. The charge nurse Emergency box. The facility 's policy Interim/Stat/Emerge Exchange Drug Pro Emergency boxes " ensure that emergen nursing unit until eith of its contents is abo Facility should contar replacement."	ial, 1 of 4 vials expired ial, 1 of 4 vials expired 1 of 11 tablets expired 8 tablets expired betweed 1 February 2008 2 tablets expired Dece 2	d January en d between ember ring the the time n August Employee es should n the lled. he tions, stem, and should the wn or one r case, a 0 AM, the served.	L 161			
Health Regula	ation Administration						_

STATE FORM

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008			
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	DE AT ROCK CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGUL ENTIFYING INFORMATION)	LATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHC REFERENCED TO THE APPROPRI/	ULD BE CROSS-	(X5) COMPLET DATE		
L 161	Continued From pa	ge 34		L 161	1 Lossponer and				
	 (2) Vitamin K ampoules and one (1) Lidocaine 2% 20 ml vial were removed. A face-to-face interview was conducted at that time of the observation with Employee #14. He/she acknowledged that the emergency box should have been replaced. L 168 3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to label drugs in accordance with currently accepted professional principles. The findings include: The Charge nurse failed to date and initial multidose medication vials when opened. On August 6, 2008, at approximately 11:00 AM, during the inspection of the upper and lower level medication storage areas, the following medications were opened with no date or initials: PPD 10 Test Aplisol Tuberculin Purified Protein Derivative 5 TU Lorazepam 2 mg/ml inj. 4ml vial Bacteriostatic Water 30 ml Morphine Sulfate 20mg/ml 30 ml bottle 		nat time she		 Lorazepam and Mrophpine Sulfat discarded. The other med ca were checked for medications that be under lock and may stored impro- 	arts other should d key or			
L 168				L 168	3. The licensed staf educated on the handling and stor	f will be proper			
			ional ssory tion acility		controlled drugs (Schedule II) All license nurses required every sh check the med ca medications that be under double and stored correct according to spec	nift to arts for need to lock ctly c.			
			AM, Ievel		The 11-7 supervi audit the unit med weekly to insure controlled drugs a stored properly a medications that be stored in the refrigerator are st	d carts are nd need to			
					correctly. A list of drugs and biological that mu stored in the a co temperature will b in the MAR	ist be introlled			
		nowledged that the vials I ed and/or initialed at the							

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD02-0008		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SL COMPLE	IRVEY TED 1/2008		
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L 183	and progress notes resident's social con- each resident's med and revised as need This Statute is not Based on record re (3) of 15 sampled re facility staff failed to notes for Residents The findings include A. Review of the clin revealed that the re current quarterly so quarterly social wor April 11, 2008. A face-to-face intern Employee #6 on Au 4:00 PM. He/she a not on the record. If here a few months. remain current but I moving forward." T August 5, 2008. B. A review of the co revealed that the re current quarterly so social work note on 2008. A face-to-face intern	hent and evaluation, pla , including changes in ndition, shall be incorp dical record, reviewed essary. met as evidenced by: view and staff intervier esidents, it was detern o write quarterly social s #4, #6 and #10. e: nical record for Reside cord lacked evidence cial work notes. The la k note on the record w view was conducted w igust 7, 2008 at appro- cknowledged that the He/she added, "I have I am trying to catch u am not going back. I he record was reviewed clinical record for Resi cord lacked evidence cial work note. The las the record was dated view was conducted w ugust 7, 2008 A at app	the orated in quarterly, w for three hined that service ent #4 of a ast vas dated with ximately note was only been p and am ed on dent # 6 of a at quarterly April 17, ith	L 183	Inspection of the med carts ar med rooms will be part of the nursing rounds with the DON \$. The DON will present to the Committee the systemic meas put in place to insure the defice practice does no reoccur The Don will review the audits looking for trends and area of noncompliance. The trends a areas of noncompliance will be discussed by the QA Committee The QA Committee will detern the effectiveness of the plan of correction and make recommendations for changes	e QA sure ient nd e ee. nine of			

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L 183	that the note was not on the record. He/she added,			L 183				
	"I have only been here a few months. I am trying to catch up and remain current but I am not going back. I am moving forward." The record was reviewed on August 6, 2008.							
	revealed that the red current quarterly so	linical record for Resid cord lacked evidence cial work note. The las the record was dated	of a st quarterly					
	A face-to-face interview was conducted with Employee #6 on August 7, 2008 at approximately 4:00 PM. He/she acknowledged that the note was not on the record. He/she added, "I have only been here a few months. I am trying to catch up and remain current but I am not going back. I am moving forward." The record was reviewed on August 7, 2008.							
L _. 189	program or his or he	of the director of the a		L 189				
	following: (a)To provide directi program	ion and quality guideli	nes of the					
		naintain a plan for the implementing the plan						
	number and levels o	et for the program, in f employees to be hir plies to be purchased;						
	(d)To coordinate and	d integrate the progra	m with		· · · ·			
Health Degula	tion Administration							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPI A. BUILDING B. WING		(X3) DATE SU COMPLET	ſED	
		HFD02-0008	3050 MILIT	08/11/2008 DDRESS, CITY, STATE, ZIP CODE ILITARY ROAD NW NGTON, DC 20015				
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L 189	other resident care and in the commun (e)To assist in the o staff orientation and all staff in the facilit (f)To develop a writ in a large print cale location of each sci (g)To post the activ working day of each a height that can be wheelchairs; (h)To assure that vi impaired residents (i)To assess the the interests of each re of admissions; and (j)To participate in t interdisciplinary car resident's response	services provided in th ity; development of and par d annual education prog y; tten monthly activities s ndar that includes date heduled activity; ities schedule on the fil h month at each nursing clearly seen by reside isually, hearing and cog know about posted activity erapeutic activity needs sident within fourteen (the development of an re plan and reassess each each resident his or he	ticipate in grams for chedule , time and st g unit, at nts in gnitively vities; and 14) days ach uarterly	L 189	 Resident #4 w completed Act The Activities do a chart aud all resident ha completed up The Activities complete a main insure a activities complete a main insure a activities place . (Quarta The Activities present to the committee the measure put in place to insure the practice does not in The Activities Dire review the audits I trends and areas of noncompliance. T and areas of nonc will be discussed & Committee. The O will determine the of the plan of corre- make recommend corrections to the insure consistent of 	tivities note Director will dit to insure ve a to date audit. Director will onthly audit to ty note is in erly note) Director will QA e systemic n deficient reoccur ector will ooking for of The trends ompliance oy the QA QA committee effectiveness ection and ations for plan to		
	Based on record re (1) of 15 sampled re	is Statute is not met as evidenced by: sed on record review and staff interview for one of 15 sampled residents, it was determined that illity staff failed to provide quarterly Activities tes for Resident #4.						
	The findings include	9:						
	A review of the clini	cal record for Resident	#4					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE HFD02-0008		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008	
NICLESIDE AT BOCK OBEEK 3050 MIL			3050 MILIT WASHING	RESS, CITY, ST FARY ROAL TON, DC 20 ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH	DRRECTION HOULD BE CROSS-	(X5) COMPLE
L 189	Continued From par revealed that the re current quarterly ac Activities note on the 2008. A face-to-face inten Employee #5 at app 6, 2008. He/she sta writes the notes. La acting in that capace on August 5, 2008. 3232.3 Nursing Fac Summaries and ana reviewed at least m designee in order to safety hazards and This Statute is not Based on observation determined that fac three (3) day supply the premises as record The findings include A tour of the emerge on August 4, 2008 a observed: one (1) c juice four (4) cases, pudding cups, one (2) A face-to-face interviewed at the main of the emergen on August 4, 2008 a observed: one (1) c juice four (4) cases, pudding cups, one (2)	cord lacked evidence o tivities note. The last q ie record was dated Ma view was conducted with proximately 9:30 AM on ated "The supervisor us am not the supervisor us an not the supervisor us of non-the accurrence. The second accurrence of the patterns of occurrence met as evidenced by: on and staff interview, i ility staff failed to mainta of non-perishable stap quired by state law. e: ency food area was cor at 4:15 PM and the follo ase of tropical fruit, crain approximately 3 cases (1) case of tuna fish. view was conducted witt e time of the observation and stated, " We d	uarterly irch 11, th August sually I am only eviewed be ator or ealth and it was ain a bles on houcted owing was nberry s of	L 189	 REFERENCED TO THE APPROPRIATE 6. Facility staff failed to diswaste as required by state 1. Emergency food was a during the time of insp 2. These items are assig separate area in the D Room. The Emergency shelf stable but has a life, the food will be uticafé and replaced so constant supply of foo 3. The Disaster Plan for a services is in place. A food is assigned for us period. This food is or inventory so that it is not the regular food supply 4. The Food Service Director the use and the inventor monthly. The Food Service Director the systemic changes to the committee to insure the depractice does not reoccur. The Food Service Director the audits looking for trend of noncompliance. The Q/will determine the effective plan of correction and mak recommendations to insure 	pose of food law. bbtained ection. ned a ry Storage cy Food is 6 month shelf lized in the that a d is available. dining ll emergency se in a 3 day n a separate not included in y. ector will audit ory supply will present he QA eficient will review ls and areas A Committee mess of the te	DATE

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AME OF PE			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
				TARY ROAD TON, DC 200			
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L 206	Continued From pa	age 39		L 206			
	3232.4 Nursing Fai Each incident shall record and reported forty-eight (48) hou incidents and accid resident shall be re- within eight (8) hou This Statute is not Based on observat interview for four (4 11 supplemental re- the facility failed to of neglect or abuse source were invest Agency. Residents M4, M6, M7, M8, W The findings includ 1. Facility staff faile injury of unknown s Resident #2. A review of Facility revealed: July 14, 2008 at 11 purple bruise R arm unknown. " July 30 2008 at 12: noted on Right Nos	cilities be documented in the d to the licensing agen irs of occurrence, exce lents that result in harn ported to the licensing irs of occurrence. met as evidenced by: ion, record review and b) of 15 sampled reside esidents, it was determ ensure that all alleged e and injuries of unkno tigated and reported to s: #2, #9, #13, #14, A3 19, M10, M12 and M14	cy within pt that n to a agency staff ents and ined that violations own o the State b, F6, M3, 4. port an ency for orts Dark ause c) Skin tear	L 206	 Resident #14, M14 M7 have discharged. Residents #2, #9 # M3 M4 M8 M10 wi investigated to det the resident was a if disciplinary actio for staff involved a incident report faxe DOH All incident reports to August 11th to prese injures of unknown orig investigated and report DOH Educate all staff on A Further education for staff on their respon investigating and re abuse and suspect and about disciplin for the employee in abuse. Revise the Inciden policy and procedu include a receipt m obtained when the report and DOH for the DOH The DOH form atta incident form must interventions to kee resident safe 	been 13, A3 F6 II be ermine if bused and n is needed nd the ed to the dating back nt involving gin will be ted to the abuse the licensed nsibility for eporting ted abuse ary action hvolved in t Report res to just be incident r is faxed to include	

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI HFD02-0008		(X2) MULTIP A. BUILDING B. WING		- (X3) DATE SURVEY COMPLETED 08/11/2008	
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#2 we Both e been i The re 2. Fac injury Reside A revie reveal July 9 on righ There source Agence Face-1 were o Both e been i The re 3. Fac injury Reside A revie reveal July 9 on right There source Agence A revie reveal July 9 on right There source Agence The re source Agence The re source Agence The re source as the source as the sourc	employees st nvestigated cord was re- cility staff fail of unknown s ent #9. ew of the Fac ed: , 2008 at 4:3 nt upper arm was no evid e was investi avas no evid e was investi avy. co-face interv conducted or employees st nvestigated of ecord was re- ility staff faile of unknown s ent #13. ew of Facility ed: 8, 2008 at 5 red with bluis heek. Bilate oted with bluis heek. Bilate oted with bluis heek. Bilate	d on August 7 , 2008 at ated the above incider or reported to the State viewed August 7, 2008 ed to investigate and r source to the State Age cility Incident /Accident	eport an ency for a reports ear noted unknown to State #1 and #2 30 PM. at had not e Agency. bort an ency for port an ency for ports was velling of t forehead se unknown	L 206	 The Care Plan must be upd by the licensed nurse with m interventions that prevent reoccurrence of the incident The Incident Investigation F must be completed and atta to the Incident Report This Form does not go to the sta The interdisciplinary team w review incident reports at St Up meeting daily to insure m interventions are in place or further investigation is need Once the Incident Report is completed they are submitted the DON for be audited. The DON will submit to QA committee the syste measure put in lace to prevent the deficient pra- from reoccurring. The DON will trend the incid reports looking at Patterns involving staff Diagnosis Mental Status Types of injuries Time of Day Need for training and other areas suggested the QA Committee will disc the QA Committee will disc the trends and areas of 	ew orm ched ste. ill and ew if ed ed to the mic actice lent	

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L 206	Agency. Face-to-face interviewere conducted on Both employees statistic on the record was reviewed on the record was reviewed. 4. Facility staff failed unknown source for A review of Facility I revealed: May 1, 2008 at 1:30 observed skin tear reviewed skin tear review of skin tear reviewed skin tear reviewed skin tear reviewere conducted on the source was investig. Agency. Face-to-face interviewere conducted on the source was investigated of the record was reviewer conducted on the source of the record was reviewere conducted on the source of the record was reviewere conducted on the source was reviewere conducted on the source was reviewere conducted on the source was reviewere conducted on the record was reviewere conducted on the record was reviewere conducted on the source was reviewere conducted on the source was reviewere conducted on the source was reviewere conducted on the record was reviewere conducted on the rec	ews with Employees #1 a August 7 , 2008 at 4:30 ted the above incident h r reported to the State A ewed August 7, 2008. d to investigate an injury	PM. ad not gency. of s ime. ime. ime. ime. ime. ime. ime. ime.	noncompliance , effective plan of correction and red corrections to the plan to compliance.	commend			

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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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPL (X5) COMPL		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME HFD02-0008		(X2) MULTIPL A. BUILDING B. WING		(X3) DATE SI COMPLE		
INGLESIDE AT ROCK CREEK 3050 MILITARY ROAD MW WASHINGTON, DC 20015 MAID PREEX TAG SUMMARY STATEMENT OF DEPICIENCIES OR US OF DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY PREEX PREEX TAG PROVIDER'S FLAN OF CORRECTION SHOULD BE CROSS- OR US OF DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY PREEX TAG PROVIDER'S FLAN OF CORRECTION SHOULD BE CROSS- DEPICENCY COME L 206 Continued From page 42 L 206 L 206 Image: Comparison of	NAME OF PR			STREET ADD					
Preferx TXG CEACH DEPRICEMENT WINST BEFRECEDED BY FULL REGULATORY PREFR CEACH CORRECTVE ACTION SHOULD BE CROSS- DEPT TXG COMPL L.206 Continued From page 42 L<206 Etiology Unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. L 206 Face-to-face interviews with Employees #1 and #2 were conducted on August 7, 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 6. Facility staff failed to investigate and/or report an injury of unknown source to the State Agency for Resident F6, who was observed with skin tear right wrist, skin tear left arm and bilateral darkened red eyes. A review of Facility Incident /Accident reports revealed. May 7, 2008 at 10:52 AM: "[Resident F6] was noted with skin tear on an old bruise 4cm X 1 cm Left arm color is red Origin unknown." May 26, 2008 "Kin tear observed on right wrist." A review of Resident F6]with both eyes dark redsee chart." "June 15, 2008 "Skin tear observed on right wrist." A review of Resident F6]with both eyes dark redsee chart." "June 15, 2008 "Skin tear observed on right wrist." A review of Resident F6] record revealed the following nursing notes: May 26, 2008 at 11:00 [AM/PM not indicated], " Left eye 2 x 1.75 x 0x 0 cm (centiumeters) no opening dark red in color. RCC [resident care coordinatof] made aware, nursing will continue						W			
 Etiology Unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7, 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 6. Facility staff failed to investigate and/or report an injury of unknown source to the State Agency for Resident F6, who was observed with skin tear right wrist, skin tear left arm and bilateral darkened red eyes. A review of Facility Incident /Accident reports revealed: May 7, 2008 at 10.52 AM: "[Resident F6] was noted with skin tear on an old bruise 4cm X 1cm Left arm color is red. Origin unknown." May 26, 2008 "[Resident F6]:with both eyes dark redsee chart." "June 15, 2008 "Skin tear observed on right wrist." A review of Resident F6's record revealed the following nursing notes: May 26, 2008 at 11:00 [AM/PM not indicated], "Left eye 2 x 17.5 x 0.0 C on (centimeters) no opening dark red in color. RCC [resident care coordinatof] made aware, nursing will continue 	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION S	HOULD BE CROSS-	(X5) COMPLETE DATE	
following nursing notes: May 26, 2008 at 11:00 [AM/PM not indicated], " Left eye 2 x 1.75 x 0x 0 cm (centimeters) no opening dark red in color. Right eye 1.25 x 2.5 x 0 x 0 no opening dark red in color. RCC [resident care coordinator] made aware, nursing will continue		Etiology Unknown." There was no evide source was investig Agency. Face-to-face intervie were conducted on Both employees sta been investigated o The record was revie 6. Facility staff failed injury of unknown se Resident F6, who w wrist, skin tear left a eyes. A review of Facility I revealed: May 7, 2008 at 10: noted with skin tear Left arm color is red May 26, 2008 "[Res redsee chart."	nce that the injury of u ated and/or reported t ews with Employees # August 7 , 2008 at 4:3 ited the above inciden r reported to the State ewed August 7, 2008. d to investigate and/or ource to the State Age as observed with skin arm and bilateral darke incident /Accident reports 52 AM: "[Resident F6] on an old bruise 4cm Origin unknown." ident F6]with both e	to State 41 and #2 30 PM. t had not Agency. report an ency for tear right ened red orts Was X 1cm yes dark					
		following nursing no May 26, 2008 at 11: Left eye 2 x 1.75 > opening dark red in x 0 no opening dark care coordinator] ma	tes: 00 [AM/PM not indica (0x 0 cm (centimeters color. Right eye 1.25 red in color. RCC [re	ted], " s) no x 2.5 x 0 sident					

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NAME OF PR			STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
	DE AT ROCK CREEK			TARY ROAD TON, DC 200				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLETE DATE	
L 206	Continued From page 43 May 27, 2008 at 11:00 [AM/PM not indicated], " Resident receives eye drops, that [his/her] skin is also fragile and that [he/she] bruises easily. Staff has been made aware that gentle pressure should be applied when administering eye drops. " A face-to-face interview was conducted with Employee #2 on August 7, 2008 at approximately 2:30 PM. He/ she stated, "There was no investigation and we didn't report it to the state." The record was reviewed August 7, 2008. 7. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M4. A review of Facility Incident /Accident reports revealed: July 12 2008 at 1:00 PM, "observed dark purple bruise on right/ left buttock. Etiology Unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2			L 206				
	 been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 8. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M6. A review of Facility Incident /Accident reports 							
	tion Administration							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SL COMPLE		
		111 202 0000	STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
	ROVIDER OR SUPPLIER		3050 MILI	TARY ROAD	NW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPF	IOULD BE CROSS-	(X5) COMPLETE DATE	
L 206	residents right lower right arm with small cleansed and dress There was no evide source was investig Agency. Face-to-face intervitive were conducted on Both employees statistic been investigated of The record was review 9. Facility staff faile injury of unknown s Resident M7. A review of Facility revealed: May 12, 2008 at 2:- elbow possibly due There was no evide source was investig Agency. Face-to-face intervitive were conducted on Both employees statistic been investigated of The record was review	30 PM, " bruise /abra er arm; noted with skin I amount of bleeding an sing applied." ence that the injury of u gated and/or reported t iews with Employees # August 7 , 2008 at 4:3 ated the above inciden or reported to the State viewed August 7, 2008. d to investigate and re- source to the State Age Incident /Accident reported 40 PM, " skin tear or	tear on rea Inknown o State 1 and #2 0 PM. ts had not Agency. orts n right Inknown o State 1 and #2 0 PM. thad not Agency.	L 206				
Health Regula	ation Administration							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIP A. BUILDING B. WING			DATE SUF	
		HFD02-0008					08/11	1/2008
	ROVIDER OR SUPPLIER		3050 MILI	RESS, CITY, STA TARY ROAD TON, DC 200	NW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REC		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE ACTI REFERENCED TO THE APP	ON SHOULD BE CRO		(X5) COMPLETE DATE
L 206	OR LSC IDENTIFYING INFORMATION)			L 206				
	observed with skin t unknown." There was no evider	PM: "[Resident M9] w lear right elbow Or nce that the injury of u ated and/or reported to	igin nknown					
	Face-to-face intervie	ws with Employees #	1 and _					
lealth Regula	tion Administration							

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<u>Health R</u>	egulation Administrat	tion							
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIF A. BUILDINC B. WING	PLE CONSTRUCTION	(X3) DATE SL COMPLE	TED .		
		HFD02-0008		ADDRESS, CITY, STATE, ZIP CODE 08/11/2008					
			3050 MILI	ILITARY ROAD NW NGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES TEE PRECEDED BY FULL REG NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE		
L 206	Both employees sta been investigated of The record was revi 12. Facility staff fail unknown source for A review of Facility I revealed: June 10, 2008 at 11 tear below right ank There was no evider source was investiga Agency. Face-to-face intervie were conducted on A Both employees stat been investigated of The record was revi 13. Facility staff fail unknown source for A review of Facility I revealed: June 10, 2008 at 8:3 noted with skin tea ,5cm and 2cm X 1 c	on August 7 , 2008 at ted the above inciden r reported to the State ewed August 7, 2008. ed to investigate an ir Resident M10. Incident /Accident rep :15 AM, "Resident le measured 2cm X 20 nce that the injury of u ated and/or reported t ews with Employees # August 7 , 2008 at 4:3 ted the above inciden r reported to the State ewed August 7, 2008.	t had not Agency. ajury of orts with skin cm." unknown o State 1 and #2 0 PM. t had not Agency. ajury of orts 2] was 1 1cm X y drainage middle	L 206					
Health Regula	tion Administration								

Health R	egulation Administra	tion						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
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L 206	 Continued From page 47 There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 14. Facility staff failed to investigate an injury of unknown source for Resident M13. A review of Facility Incident /Accident reports revealed: June 19, 2008 at 1:55 PM: "Resident M13 skin tear noted right Lateral leg when transferring from wheel chair to bed." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 15. Facility staff failed to investigate an injury of unknown source for Resident M14. A review of Facility Incident /Accident reports revealed: June 19, 2008 at 2:00 PM: "Resident M14 CNA 			L 206				
Health Regula	tion Administration			<u> </u>	<u> </u>		<u></u>	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD02-0008		(X2) MULTIPI A. BUILDING B. WING		(X3) DATE SUR COMPLET	ED .		
			STREET ADD	STREET ADDRESS, CITY, STATE, ZIP CODE					
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETE DATE		
L 206	 while giving care." There was no evided source was investig Agency. Face-to-face interviewere conducted on a Both employees state been investigated on The record was reviewere conducted on Both employees state been investigated on The record was reviewered and the interviewere conducted on The record was reviewered and the interviewere conducted on The record was reviewered and the interviewere conducted on Based on observation was determined that maintenance services that the facility was not an appliances, drains, or refrigerator, floors, we damaged and/or matching tiles, dusty ar and carts. A tour of the main ki 4, 2008 from 8:45 Al of Employee #27 an acknowledged at the The environmental to 	kin tear on resident 's nce that the injury of u ated and/or reported to ews with Employees # August 7 , 2008 at 4:3 ted the above incident r reported to the State ewed August 7, 2008. ilities ovide housekeeping a es necessary to mainta- rior of the facility in a mfortable and attractiv met as evidenced by: ons during the survey p t housekeeping and es were not adequate maintained in a safe a evidenced by: soiled k compressor in the wall vheelchairs/chairs/geri med/or soiled medication tchen was conducted M to 11:45 AM in the p	Inknown o State 1 and #2 0 PM. had not Agency. and ain the safe, re period, it to ensure nd itchen chairs; rds, walls, n rooms on August presence ons. August	L 206	L410 3256 Nursing Facilitie Dietary A, B, C, D, E, F, G, J. K. L. M. N, O were all clear replaced. Item C. Additional Hangers installed Item D Additional dunnage purchased and items remo from the floor during inspece 2. All equipment is on a d cleaning schedules wh included floors, drains, machines, walls. Utility workers are responsible for all equi in the closet including r buckets and squeeges During deliveries all bo will be delivered to the proper locations off the 3. Cleaning list includes a super visor check to be monitored weekly. The Food Director will comp a grand check monthly Staff have been inservi on the cleaning schedu Utility staff have been inservices	H, I. eaned as s rack ved ction laily ich ice pment mops, exes e floor			
Health Regula	tion Administration								

ND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008	
		HFD02-0008				08/	1/2008
3050 MILIT			DRESS, CITY, STATE, ZIP CODE ITARY ROAD NW STON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	ILD BE CROSS-	(X5) COMPLETE DATE
L 410	2008 from 9:40 AM Employees #27 and acknowledged at the An inspection of the conducted on Augus approximately 8:30, presence of Employ findings were ackno observations. The findings include 1. The following app observed soiled in the the health care unit(A. Gas stove in one B. Double Convection ovens observed; C. Deep fryer in one observed; D. Double Steamer observed; E. Broiler in one (1) F. Hot box near stov observed; G. Juice machine up three (3) juice mach H. Ice machine in th pantries on the heal three (3) ice machin I. Tilt skillet soiled in observed; J. Drains in main kitk kettles in two (2) of the K. Soiled compresson (1) of one (1) observed	I to 10:20 AM in the provide the second seco	re tions. carts was the contries was the contries on observed; two (2) ryer steamer erved; 1) hot box he (1) of oth e (3) of coth e (3) of coth e and the cor in one	L 410	 4. The Food Service Dire present the systemic of made to the QA Comm for recommendations insure the deficient prodoes not reoccur. The Food Service Dire review audits/schedule looking at trends and a noncompliance. The fand areas of noncomp will be discussed by the Committee in the QA Committee will determ effectiveness of the ple correction and make recommendations. The fousekeeping and Maintenance Housekeeping and Maintenance PQA all ceiling tile replaced. C. carpet in room 182 190 were replaced D. the two Geri Chair been cleaned F. the horizontal surfat the bed frames for room 45, 71, and 80 G. The damaged bed commode in 70 was discarded 	changes nittee to actice ector will es areas of rends bliance he QA nine the an of the plan s and s have acces of ms 41,	

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB HFD02-0008		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2008		
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	INCLESIDE AT BOCK OBEEK 3050 N			TARY ROAD NW TON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REC NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE (BE CROSS-	(X5) COMPLETE DATE	
L 410	soiled in eight (8) of (2) of two (2) freezer N. Kitchen floor mat (3) of three (3) floor O. Soiled floor in be (1) observed; P. The women bathr with solid ceiling tile Q. Ceiling tiles were in the health care ur 2. Additional areas in follows: A. Ceiling tiles were dining room, lower le rehabilitation gym B. In the Beauty Sho observed with hair in rollers observed; C. Carpeting in five(41, 81, 88, 182 and corridor on rehabilita D. Chairs gerichairs observed soiled in s 80, 94 and 170 and dining room in six (6 E. 0xygen concentra soiled in two (2) of fi 170 and 88; F. Horizontal surface 26 rooms observed, G. A bedside common with a brown substate rooms observed	ved soiled; freezer floors were ob eight (8) refrigerators is were observed; ts were observed; verage closet in one (coom/locker room was is in one (1) of one (1) stained/soiled in both its; in the facility were obs soiled in Rooms 43, r evel day room and the op: Hair rollers stored in five (5) of five (5) cor 5) of 26 rooms observ 190, the linen closet a ation unit were observe and/or wheel chair we ix (6) of six (6) observ three (3) in the lower	and two ed in three 1) of one observed observed; pantries erved as ehab for reuse ntainers of red, rooms and the ed ere ed rooms level ved to , rooms ur (4) of d 80; oserved 1) of 26	L 410	 A. The day room will have guards installed along walls C The arms of the chairs of first floor day room were cleaned. B The ceiling tiles will be replaced c. Damaged light fixture I missing light bulbs on LL were replaced. D. The light repaired and replaced in the men bathr E. The hole in the womer bathroom was repaired H. The rusted air vents w primed and painted I The lights in rooms 41, 4 and 46 were placed K. Night lights in room 71, 81, 97 were replaced L. The damaged night stat were removed form room 190and the table and dress were removed form 80 All areas of the Health Center will be audited areas that need maintenance attentior The Facilities manger Maintenance Supervis will make rounds weekly I or opportunities for repsiling will be submitted 	g the in the JL and level cover oom n's ere 3, 42, 72, 80, ands sser for for for n. , the sors ooking pairs. oom Form		

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		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUME HFD02-0008				(X3) DATE SURVEY COMPLETED 08/11/200	
3050 MILIT		ITARY ROAD NW GTON, DC 20015					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE ACTIO TAG REFERENCED TO THE APPE		HOULD BE CROSS-	(X5) COMPLET DATE	
L 410	marred/scarred: A. The day room w rooms observed. B. Walls were obs observed, rooms # C. Arm chairs in th of seven (7) chairs dining room six (6) 3. The following ite damaged: A. The wall near th from steam kettle w of one (1) wall observed damaged. B. Ceiling tiles were pantries in the heal closet in located in laundry room; C. Damaged light f light fixture, lower h of two (2) observed D. The men's bath employees was ob light and missing ct E. The women bath with a hole in wall i F. Beverage closet of one (1) observed G. The foot pedal co upper pantry did no manual opening of of trash in one (1) of August 7, 2008 at 8 H. Rusted air vent one (1) of two (2) at I. Lights were observed	valls in two (2) of three erved in four (4) of 26 42, 45, 46 and 97 e first floor day room ir observed, rehabilitation of six (6) chairs ems/areas were observed erved in the main kitch station on rehabilitation d; e missing/damaged in the care units, in the beat the main kitchen and it ixtures: upper pantry d had missing light bulbs for oom/locker room for k served with a non-func- over over the light. hroom/locker room for k served with a non-func- over over the light. hroom/locker room was n one (1) of one (1) ob had broken light cover d f the trash receptacle of the trash receptacle of the trash receptacle of two (2) trash recepta 3:18 AM. in the pot and pan was	rooms a seven (7) on unit ed across d in one (1) en; the n unit was both everage in the amage in two (2) itchen ctioning s observed served. r in one (1) in the ed, and o dispose acles on th area in d/or not	L 410	office to be placed on a form for repair. The Maintenance Supe audit the Room and Sp inspection form weekly rooms t insure items have repaired Cleaning Schedules will established for carpets daily The Housekeep Supervisor will make ro and document on the H rounds list the carpets to been cleaned. The med carts will be in Housekeeping daily cle schedule. Wheel chairs will be cle room number one each wheel chair schedules to on the units. The House Supervisor will do a wee insure the wheelchairs a cleaned. 4. The Director of Facil present the systemic me the QA committee for recommendations to insideficient practice does of	rvisor will ace by making ve been I be to be cleaned ing unds daily ousekeeping hat have ncluded in the aning aned daily by unit. The will be posted sekeeping ekly audit to are being ities will easures to sure the	

Health Regulation Administration STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ND PLAN UI	CORRECTION			A. BUILDING		COMPLETED	
		HFD02-0008		RESS, CITY, STA		. 08/1	1/2008
	OVIDER OR SUPPLIER		3050 MILIT	TARY ROAD	NW		
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		I in room of 26 and 97; owing rawer was le stand ser in ed on observed es stored observed of three dry erved. led in two on August	L 410	The Director of Facilitie review the schedules at looking for trends, and a noncompliance. The tre areas of noncompliance discussed by the QA co The QA committee will determine the effectiver the plan of correction at recommendations for co to the plan to insure cor compliance. 6. Medication carts – N medication carts were of All the nurses will be re- clean their carts after ev They will be monitored of nursing weekly rounds. do a though cleaning ev Wednesday.	nd audits area of ands and e will be mmittee . ness of nd make prrection nsistent ew obtained . quired to very shift. on the !!07 will		
L 999	DC CODE			L 999			
lth Regula TE FORM	tion Administration		. 68	C	DXJZ11	If continuat	ion sheet 53 c

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: · HFD02-0008			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED - 08/11/2008			
	3050 MILIT			DRESS, CITY, STATE, ZIP CODE ITARY ROAD NW STON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIÉNCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE	
L 999	This Statute is not following nurse's no PM, "Resident move number]." There was no evide physician was notifie B. On August 4, 200 stated, " I just move A review of Residen note dated July 19, [Resident P1] was the to [room number]." There was no evided physician was notified A face-to-face intervice conducted on August stated, "Both resided rooms. I notified the	met as evidenced by: te dated July 11, 2008 ed from [room number] nce in the record that t ed of the resident' s rel 08 at 9:38 AM, Resider d. I don't like my room at P1's record revealed 2008 at 11:00 PM, " ransferred from [room n nce in the record that t ed of either resident's r view with Employee #12 st 7, 2008 at 9:15 AM. nts were moved to diffe ir families. I didn't kno physician." The record	to [room he ocation. ht P1 ." a nurse's number] he relocation. 2 was He/she erent bw that I	L 999	 #P1 This residues been transferre #JH2 The physe made aware of #3 The family we aware Review of the condentify other research have had a room Once identified and physicians notified. The Social Word develop a room policy Initiate the DC 6 for all facility room Educate the lice the Dc 6108 and Change policy a procedure The licensed states the DC6108, not Family and or resparity and documented on report. The Social Word the condense of the conden	d. sician was the transfer vas made ensus will sidents who m change. the family have been ker will change 5108 Form om changes ensed staff on d the Room and aff will initiate otify the MD, esponsible ment this he medical ge must be the 24 hour ker will audit y for room sure there is		

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		HFD02-0008				08/11	/2008
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE		
INGLESI	DE AT ROCK CREEK			ARY ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
L 999	Continued From page	 ge 54		L 999			
Based on staff interview and record review for one (1) of 15 sampled residents and two (2) supplemental residents, it was determined that upon relocation of residents to another room within the facility, facility staff failed to notify the responsible party for one (1) resident and the			The Social Worker will review the audit looking for trends in areas of non compliance. The QA Committee will discuss the trends and areas of noncompliance. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for				
	physician for two (2) residents. Residents #3, P1, JH2.				corrections to the plan to compliance.	o insure consistent	
	The findings include	2:				``	
		d to notify Resident #3 hen he/she was reloca the facility.					
	an "Interim Order Fo [patient] to the LL [L	t #3's clinical record re orm" that indicated "T ower Level] Unit Rm. and all personal belo	ransfer pt. [Room] #				
	the responsible part	nce in the resident's re y was informed of the ident's room change o					
A face-to-face interview was conducted on Augus 5, 2008 at approximately 4:15 PM with Employee #2. He/she acknowledged that the resident's clini record lacked evidence that the responsible party was notified when the resident changed rooms. T record was reviewed August 5, 2008		nployee nt's clinical ble party		2			
		t to notify the physicia P1 were relocated with					
	A. Review of Reside	ent JH2's record revea	led the				

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