Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments 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. 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 physician for two (2) residents. Residents #3, P1, JH2. The findings include: 1. Charge nurse failed to notify Resident #3's responsible party when he was relocated to another room within the facility. 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..." There was no evidence in the resident's record that the responsible party was informed of the aforementioned resident's transfer order. A 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 responsible party was notified of the aforementioned transfer order. The record was	L 000	1. #P1 – This resident has never been transferred 2. #JH2 – The physician was made aware of the transfer 3. #3 – The family was made aware. 2. Review of the census will identity other residents who have had a room change. Once identified the family and physicians have been notified 3. The Social Worker will develop a room change policy. Initiate the DC 6108 Form for all facility room changes Educate the licensed nurse staff on the DC 6108 and the Room Change policy and procedure	10/2/08 10/2/08 10/2/08 10/2/08

Health Regulation Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Chris K. Schaff, Administrator — 9/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1 reviewed August 5, 2008 2.Charge nurse failed to notify the physician when Residents JH2 and P1 were relocated within the facility. A. Review of Resident JH2's record revealed the following nurse's note dated July 11, 2008 at 10:00 PM, " Resident moved from [room number] to [room number]." There was no evidence in the record that the physician was notified of the resident' s relocation. B. On August 4, 2008 at 9:38 AM, Resident P1 stated, " I just moved. I don't like my room." A review of Resident P1's record revealed a nurse' s note dated July 19, 2008 at 11:00 PM, " ... [Resident P1] was transferred from [room number] to [room number]." There was no evidence in the record that the physician was notified of either resident's relocation. A face-to-face interview with Employee #12 was conducted on August 7, 2008 at 9:15 AM. He/she stated, "Both residents were transferred. I notified their families. I didn't know that I needed to notify the physician." The records were reviewed August 4, 2008.	L 000	The licensed staff will initiate DC6108, notify the MD, Family and or responsible party and document this information in the medical record. The room change must be documented on the 24 hour report. 4. The Social Worker will audit the census daily for occurrences of room changes and insure there is a completed DC6108. The Social Worker will present to the QA Committee the systemic measures put in place to insure compliance and for QA Committee recommendations. The Social Worker will present monthly findings from the audit to the QA Committee to discuss trends and areas of noncompliance , the effectiveness of the plan of correction and make corrections to the plan to insure compliance	ongoing ongoing ongoing 9/18/08 ongoing
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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 regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindications for the 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 for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that the physician failed to: address pain management for one (1) resident and to write an order to include the diagnosis of Lipidemia for one (1) . Residents #4 and P1. The findings include: 1. Physician failed to address pain management for Resident #4. Physician's Order Sheet (POS) dated February 20, 2008 revealed an order for "Propoxyphene	L 031	L031 3207.6 Nursing Facilities 1. Resident #4 A Pain Assessment has been completed and the resident is on routine pain 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 medical record 9/24/08 2.I The medical records will be 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 3. The Medical Director will respond to the facility physician via a letter to inform them about the deficiencies obtained during the survey and remind them of the	10/2/08 9/24/08 10/2/08 10/2/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 031	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 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. The record was reviewed on August 5, 2008.	L 031	regulatory standards for physicians in long term care. The Unit Manager will audit the medical records monthly for those residents that have a diagnosis of pain have a condition that may cause pain to insure there is a care plan in place and undated, current and current pain assessment and physician note The Unit Manager will audit the medical records to insure that all medications have an appropriate diagnosis . The audits will be turned in to the DON monthly. The monthly pharmacy reports will be reviewed by the DON/Medical Director to see which physician are out of compliance with making sure an appropriate diagnosis is in place for each medication. 4. The Don will present to the QA Committee the systemic changes put in place to insure the deficient practice does not reoccur.	ongoing ongoing ongoing ongoing 9/18/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 031	Continued From page 4 2. The physician failed to write an order to include 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 for 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 signed and dated the response on May 12, 2008 for a diagnosis of Lipidemia. There was no evidence that the physician wrote an 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 August 4, 2008 at 3:00 PM with Employee #12. He/she acknowledged that the physician failed to write the diagnosis. The record was reviewed August 4, 2008.	L 031	The Don will review the audits looking for trends and areas of noncompliance. 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 corrections to the plan to insure consistent compliance. L036 3207.11 Nursing Facilities 1. The physician for resident #4 will be notified that he needs to complete a annual H&P for this resident by 10/2/08 2. All Medical Records will be audited by the Unit Clerk to insure all residents have a current annual H & P All physician out of compliance will be notified that a H & P is due. 3. The Unit Clerk will audit the medical records monthly to insure all residents have a timely H & P. The audit will be reviewed by the Unit Manager and any physician out of compliance will notified. The audit will be submitted to the DON.	ongoing 10/2/08 10/2/08 10/2/08 ongoing ongoing ongoing
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the physician failed to provide an annual health and physical examination for Resident #4. The findings include: A review of Resident #4's record revealed an annual health and physical evaluation report	L 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 036	Continued From page 5 dated July 1, 2007. There was no evidence in the record that a health and physical examination had been conducted after July 1, 2007. A face-to-face interview was conducted with Employee #4 on August 6, 2008 at approximately 4:00 PM. He/she acknowledged that the physical examination had not been completed. The record was reviewed on August 5, 2008.	L 036	4. The DON will present the systemic changes made to the QA Committee to insure the deficient practice does not reoccur. The DON will review the audits looking for trends and areas of noncompliance. 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 changes to the plan to insure consistent compliance.	9/18/08 ongoing
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observations, record review and staff interview for one (1) of supplemental	L 051	Lo51 3210.4 Nursing Facilities 1. Resident JH1 has been discharged and did not give her own medication. 2. There are no other residents at this time that administer their own medications 3. Education the licensed nurses on the policy and procedure of Self Administration of medications An order must be obtained from the physician	8/6/08 10/2/08 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 6 resident, it was determined that the charge nurse failed to assess Resident JH1 for the ability to self medicate and obtain a physician's order to self administer eye drops. The findings include: A review of Resident JH1's record revealed the following physician's orders signed August 1, 2008: " 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." 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 safe and appropriate... (4) Charge nurse should ensure that orders for self-administration list the specific medication (s) the resident may self-administer... (5) If the resident self-administers his/her medications, the charge nurse, in conjunction	L 051	The interdisciplinary team must assess the Resident for the ability to administer their own medications and document findings in the medication record. They must take the Self Administration test and pass with a 100% rate. The test will be filed on the medical record. The policy must be reviewed with the Resident and the Resident must agree to follow the facility policy On Admission when obtaining the orders it must be checked on the interim order sheet and the policy must still be followed. If a resident request to self administer after admission the above process must be followed. Residents who self administer their own medications it will noted on the kardex 4. Using the 24 hour chart audit the Nurse Manager will audit all orders for self administration of medications. The 3-11 supervisor will audit all admission records for orders for self administration of medications.	0ngoing ongoing ongoing ongoing ongoing ongoing ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 7 with the interdisciplinary team, should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility..." There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident JH1 was safe for self administration of medications. There was no physician's order to self administer medications. The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medication. A face-to-face interview was conducted on August 5, 2008 at 9:40 AM with Employee #10. He/she stated, "Resident JH1 wants to give [him/her] own medications. [He/she] wants to put drops on [his/her] eyelids and let the fluid drop in [his/her] eyes. I explained to [Resident JH1] that it was unsanitary." The record was review August 5, 2008. B. Based on record review and staff interviews for nine (9) of 15 sampled residents and three (3) supplemental residents, it was determined that 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 potential adverse interaction for the use of nine (9) or more medications and one (1) resident for pain and noncompliance with being weighed. Residents #1, 3, 4, 5, 6, 9, 10, 12,15, F6, JH3 and P1. The findings include: 1. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #1.	L 051	The Don will present systemic measure made to insure the deficiency does not reoccur. The Don will review the audits looking at trends and 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 corrections to the plan to insure consistent compliance. 1. Care plans for residents 1,3, 4, 5, 9, 10, 12, 15, F6 . JH#. P1 will all be updated. 2. The Unit Manager will audit all Health Center charts and updated all care plans. Including the deficient care plans 9 or more med, pain care plan, noncompliance , dialysis, allergies . 3. Educate the interdisciplinary team on the care planning	9/18/08 ongoing 10/2/08 10/2/08 10/2/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 8 A review of the clinical record for Resident #1 revealed physician orders dated and signed, July 7, 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 reactions 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 Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008. 2. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #3. A review of the clinical record for Resident #3 revealed physician orders dated and signed May 31, 2008 that included the following medications: "Norvasc, Aricept, Namenda, Tamsulosin, Prinivil, Lactulose, Pericolace, Multivitamins, Xalatan, Percocet, and Tylenol. There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more	L 051	The interdisciplinary Team meets weekly to review care plans the care plans must be updated during this conference insuring an interdisciplinary approach. The care plan process must include reviewing and care planning for diagnosis , infections, labs, psych consults, other MD consult, injuries. Interventions for prevention must be included. 4. The MDS Coordinator will audit all care plans due for review for the month based on the MDS schedule to insure they are complete and up to date. The audit will be turned in to the DON. The MDS Coordinator will present to the QA Committee systemic changes put in place to prevent the deficiency from reoccurring and for QA Committee recommendations The MDS Coordinator will present trends and areas of noncompliance to the QA Committee to discuss. The QA Committee will discuss the trends, areas of noncompliance, effectiveness of the plan of correction and make recommendations to the plan to insure compliance.	ongoing ongoing ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 9 medications. On August 5, 2008 at approximately 4:15 PM, a face-to-face interview was conducted with Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008. 3. Charge nurse failed to develop a care plan with appropriate goals and approaches for Resident #4's pain and use of pain medications and for continuously refused to be weighed. A. Review of the clinical record revealed that the resident was admitted to the facility on February 20, 2008 with diagnoses which include Post Polio Syndrome, Lumbar Spondylosis, UTI, Pyelonephritis, Hyperkalemia, Hyponatremia, Altered Mental Status, Acute Renal Insufficiency and Obstructive Uropathy. On admission the resident was placed on Darvocet 100/650 one (1) tab PO (by mouth) q 6hrs (every six hours) prn (as needed) for pain. A review of the MARs (Medication Administration Record) for March, April and May revealed that the resident received Darvocet as follows: for 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	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 10 received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. On June 11, 2008 a physician's order directed, "Duragesic patch 25 mg q (every) 72 hrs. Discontinue Darvocet." On June 12, 2008, a physician's order directed, " Darvocet N 100 one (1) tab q 6 hrs. prn for pain." The care plan, last reviewed on June 11, 2008, failed to reveal a care plan with appropriate goals and objectives for pain and the use of pain medications. A face-to-face interview was conducted with Employee #15 on August 11, 2008 at approximately 9:30 AM. He/she acknowledged that the record lacked a care plan for pain and the use of pain medications. The record was reviewed on August 8, 2008. B. A review of the clinical record revealed an admission note from the registered dietician which documented, "Refused to be weighed. On regular diet. Will continue assessment when weight is available." On February 26, 2008 the dietician documented, "Resident continues [to] not be weighed." The next dietary note was dated May 22, 2008 and documented, "Quarterly assessment completed." There was no mention of the resident's weight in this documentation. Review of the nurse's note dated March 11, 2008 revealed the following, "Continues to refuse wt. [weight]."	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 11 A review of the care plans last reviewed on June 11, 2008 failed to reveal a care plan with appropriate goals and objectives for the resident's refusing to be weighed. A face-to-face interview was conducted with the Registered Dietician on August 5, 2008 at approximately 3:30 PM. He/she acknowledged that the record lacked a care plan for refusing to be weighed. The record was reviewed on August 5, 2008. 4. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #5. A review of the clinical record for Resident #5 revealed physician orders dated and signed, June 20, and July 12, 2008 that included the following medications: "Brimonidine Tartrate 0.2%, Bupropion, Cosopt Ocumeter Plus, Finadteride, Lorazepam, Metoprolol, Midorine, Mutivitamin, Omeprazole, and Pyridostigmine." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions 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 Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008.	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 12 5. Charge nurse failed to develop a care plan with appropriate goals and approaches for nine (9) or more medications for Resident #6. The review of the clinical record for Resident #6 revealed a physician's order dated and signed June 10, 2008 that included the following medications: Amiodipine Besylate, Aspirin, and Calcarb. W/Vit. D, Catapress-TTS, Certagen, Cymbalta, Digoxin, Colace, Ferrous Sulfate, Lisinopril, Metolazone, Metoprolol, Lopressor and Prilosec. A review of the care plan that was last updated on July 24, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008 6. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #9. A review of the clinical record for Resident #9 revealed physician orders dated and signed, May 9, June 5, and July 10, 2008 that included the following medications: "Amiodarone, Aricept, Certagen, Docusate Sodium, Lisinopril, Metamucil, Namenda, Pantoprazole, Seroquel, Viron-C, and Albuterol Sulphate."	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 13 There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 6, 2008 at approximately 5:05 PM, a face-to-face interview was conducted with Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 6, 2008. 7 Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications and dialysis for Resident #10. A. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #10. The review of the clinical record for Resident #10 revealed a physician's order dated and signed July 1, 2008 that included the following medications: Amiodarone, Aricept, Allegra, Flomax, Lasix, Pravachol, Mysoline, Inderal, Rena-Vite, Senokot and Trazadone. A review of the care plan, last updated on June 30,2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee # 12 at approximately 10:00 AM on	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 14 August 8, 2008. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008. B. Charge nurse failed to develop a care plan with appropriate goals and approaches for Dialysis for Resident # 10. A review of the clinical record for the resident revealed that the resident was admitted to the facility on March 24, 2008 with diagnoses including ESRD (End Stage Renal Disease) and a physician's order directing, "Dialysis M, W (Monday, Wednesday) and Friday." A review of the care plans revealed no care plan with goals and approaches for dialysis. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for dialysis. The record was reviewed on August 8, 2008. 8. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #12. The review of the clinical record for Resident #12 revealed a physician's order dated and signed July 25, 2008 that included the following medications: Rocaltrol, Cardizem, Prograf, Bactrim SS, Valcyte, Clonidine, Nystatin Swish & Swallow, Stress Tabs, Nexium, Pepcid, Prednisone and Keppra. A review of the care plan, last updated on August 5, 2008, revealed that there was no care plan developed with appropriate goals and	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 15 approaches for potential adverse drug interactions involving use of nine (9) or more medications. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008. 9. Charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #15. A. Review of the clinical record for Resident #15 revealed physician orders dated and signed June 2008 that included the following medications: "CalciumCarb-VitD, Benadryl, Ferrous Sulfate, Advair, Neutrontin, Oxycontin, Senna S, Dyaziade, Dilaudid, Klor-Con, Prilosec, and Cefepime." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 8, 2008 at approximately 9:10 AM, a face-to-face interview was conducted with Employee #2. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 8, 2008. 10. Charge nurse failed to develop a care plan for Resident F6 with allergies.	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 16 A review of the "Physician Order Sheet and Plan on Care" dated February 21, 2008 and signed by the physician on February 29, 2008 revealed, "Allergies cephalosporins, codeine, penicillins and tramadol ..." A review of the care plans last updated on June 30, 2008 lacked evidence that a care plan for allergies was developed with goals and approaches to address the resident's allergies to cephalosporins, codeine, penicillins and tramadol. A face-to-face interview was conducted on August 8, 2008 at 9:30 AM with Employee #Angela. He/she acknowledged that a care plan for Resident F6's allergies was developed. The record was reviewed on August 8, 2008. 11. Charge nurse failed to initiate a care plan for adverse drug interactions for the use of nine (9) or more medications for Resident JH3. A review of Resident JH3's record revealed a physician's order from signed July 19, 2008, included 11 medications. The following medications were ordered: "Ascorbic Acid 500 mg tablet, Diovan 160 mg tablet, Folic Acid 1 mg tablet, Gabapentin 300 mg Capsule, Metoprolol Succinate 50 mg tablet , Multi-vitamin table, Polyethylene glycol 100% powder, Simvastin 20 mg tablet, Thiamine100 mg tablet, Milk of magnesium 400 mg/5 ml oral suspension and Oxycodone IR 5 mg capsule." A face-to-face interview was conducted with Employee #11 on August 4, 2008 at 11:30 AM. He/she acknowledged a care plan for Resident	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 17 JH3 for adverse drug interactions for the use of nine (9) or more medications was not initiated. The record was reviewed 4, 2008. 12. The charge nurse failed to initiate a care plan for adverse drug interactions for the use of nine (9) or more medications for Resident P1. A review of Resident P1's record revealed a physician's order signed July 2, 2008 that included the following 11 routine medications: "Atenolol 25 mg tablet, Docusate sodium 100 mg capsule, Gabapentin 100 mg capsule, Lidoderm 5% patch, Meloxicam 7.5 mg tablet, Multi-vitamin tablet, Omega-3 softgell 1000mg capsule, Oxybutynin Cl ER 5mg tablet, Sertralilne 25 mg tablet, Sertaline 50 mg tablet, Systane 0.3% - 0.4% ophthalmic drop, Warfarin 1 mg tablet, Warfarin 2.5 mg tablet, and Warfarin 4 mg tablet." A face-to-face interview was conducted with Employee #12 on August 4, 2008 at 3:10 PM. He/she acknowledged a care plan for adverse drug interactions for the use of nine (9) or more medications was not initiated for Resident P1. The record was reviewed August 4, 2008. C. Based on observations, record review and staff interview for one (1) of supplemental resident, it was determined that facility staff failed to assess Resident JH1 for the ability to self medicate and obtain a physician's order to self administer eye drops. The findings include: A review of Resident JH1's record revealed the following physician's orders signed August 1,	L 051	C 1 The resident is no longer giving her own eye drops. 2. There are no other residents at this time that administer their own medications 3. Educate the licensed nurses on the policy and procedure of Self Administration of Medications. An order must be obtained from the MD The interdisciplinary team must assess the Resident for the ability to Administer their own medications. The Resident must take a test for Self Administration of Meds. and pass with a 100% rate. The test must be filed on the medical record. The policy must be reviewed with the Resident and the Resident must agree to follow the facility policy. If a resident request to self administer after admission an order must be obtained . The Resident must be assessed, tested, policy review, and agree to follow the Self Administration policy. Place the Resident on the 224 hour report and in the Supervisors Book. The Resident must be evaluated quarterly and if there is a change in condition.	8/5/08 8/5/08 10/2/08 ongoing ongoing ongoing ongoing ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 18 2008: " 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." 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 safe and appropriate... (4) Facility should ensure that orders for self-administration list the specific medication (s) the resident may self-administer... (5) If the resident self-administers his/her medications, the Facility, in conjunction with the interdisciplinary team, should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility..." There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident JH1 was safe for self administration of medications. There was no physician's order to self administer medications. The record lacked	L 051	4. The Unit Manager using the 24 hour chart audit will monitor self administration of medications The 3-11 Supervisor will audit the all admission charts for orders for self administration The Don will present systemic measures made to insure the deficiency does not reoccur and for recommendations from the QA Committee The DON will review trends and areas of noncompliance. The QA committee will discuss the the trends and areas of non compliance and make recommendations for the plan of correction to insure consistent compliance.	ongoing ongoing 9/18/08 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 19 evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medication. A face-to-face interview was conducted on August 5, 2008 at 9:40 AM with Employee #10. He/she stated, "Resident JH1 wants to give [him/her] own medications. [He/she] wants to put drops on [his/her] eyelids and let the fluid drop in [his/her] eyes. I explained to [Resident JH1] that it was unsanitary." The record was review August 5, 2008.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	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, including oral acre; and j)Prompt response to an activated call bell or call for help. 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	L 052	1. Resident #2, and A3 were given incontinent care and the splint was washed 2. All residents will be checked to insure continence care was given on 8/6 and 8/7. 3. Incontinent Rounds will be done every 2 hour. The nursing assistants will initial on the nursing assistant rounds sheet that they have given incontinent care. The rounds sheets will be in each residents room. The licensed staff will check the nursing assistant rounds sheets daily and document on the TAR that incontinent care has been given. The Unit Manager will review the nursing rounds list weekly and submit to the DON. 4. The Don will present the systemic changes made to insure the deficient practice does not reoccur and for QA recommendations. • The DON will review the audits looking at trends	8/6,7 ongoing ongoing ongoing 9/18/08 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING ______ B. WING ______	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 21 stuffs. At 10:10 AM on August 6, 2008, Employee #3 was taken over to the resident. He was told that the resident needed to be changed and that the splint needed to be cleaned. Employee #3 responded "I will get the assigned CNA (Certified Nursing Aide) to take care of [him/her]." Employee #3 returned approximately five (5) minutes later and stated "I told the CNA. [He/she] is taking care of another resident and will come as soon as [he/she] is finished." At 10:50 AM, 40 minutes later Employee # 3 returned and stated "I went to check on the CNA. [He/She] is still with the other resident. I reminded [him/her] to come and take care of this resident when [he/she] is finished over there. " At 11:20 AM Employee # 8 walked over to the resident and proceeded to wheel him/her out of the room. When asked where he/she was taking the resident, the employee responded, "I am going to change [him/her]." At 11:35 AM, Employee #8 wheeled the resident back into the day room. The resident was still wearing the soiled splint. The employee was asked whether Employee #3 had asked him/her to clean the soiled hand splint. He/she responded "No" and added "That looks like the stuff from dinner last night, macaroni and cheese. If I take it off, I don't have another one to put on and it has to be washed." The record was reviewed August 6, 2008. 3. Nursing staff failed to provide timely incontinence care for Resident A3. The resident was observed seated in wheelchair	L 052	and areas of noncompliance . The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations to the plan to insure consistent compliance. splint There are no other residents in house with a splint Develop a policy and procedure for splint care Educate the nursing staff regarding splint care	 8/6/08 10/2/08 10/2/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 22 in the day room on August 7, 2008. At approximately 12:30 PM, the resident was observed wet with a strong urine odor bilaterally from the thighs to the waist. Approaches and intervention for an "Incontinence Care Plan" [related to recent decreased mobility] dated June 30, 2008 indicated: "Toilet every two (2) hours and as needed to decrease number of incontinent episodes. Keep resident dry, especially after each episode of incontinence." A face-to-face interview was conducted with Employee#10 on August 7, 2008 at approximately 12:30 AM. He/she said, "I am taking the resident back to [his/her] room now to provide incontinence care." Employee #10 acknowledged that the resident was last provided incontinent care in the morning, before breakfast at approximately 8:30 AM. The record was reviewed on August 7, 2008. B. Based on observation, record review and staff interview for two (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: follow physician's orders for the use of a hand splint for one (1) resident and apply a bed/chair alarm for one (1) resident. Residents #2, and F4. 1. Charge nurse failed to follow a physician's order for a hand splint for Resident #2. A review of the clinical record revealed an x-ray dated April 29, 2008 with the impression, "Fracture of the head of the fifth metacarpal." A second x-ray, dated June 12, 2008, documented, "Degenerative Joint Disease of Hand and Wrist with healing incompletely united	L 052	1. The physician gave an order for the splint to be discontinued due to non compliance for resident #2 2. Resident #F4 bed alarm was replace. Facility failed to address pain management 2, The Unit manager will assess all residents with the potential for pain and insure there is current pain assessment Facility failed to apply bed/chair alarm The Unit manager /designee will audit all residents that should have a bed/chair alarm and insure an alarm is in place 3. Educate the nursing staff on the pain management policy and procedure. The licensed nurse will audit every shift the bed and chair alarms for each resident and document placement on the TAR. Pain Management The Unit manager will do a monthly audit to insure that assessments are in place and care plans initiated and or updated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 23 spiral fracture of the distal ulna." A Report of Consultation from an orthopedic specialist dated July 31, 2008, documented, "Cast removed ... Wear protective splint for three (3) weeks. Follow up prn (as needed)." On August 4, 2008 at approximately 9:30 AM, from 11:00 AM to 12:30 AM and from 2:30 PM to 3:20 PM, Resident # 2 was observed without the hand splint on his/her right arm. On August 5, 2008 from 10:00 AM to approximately 12:00 PM the resident was again observed without the hand splint. On August 6, 2008 at 10:25 AM Resident #2 was observed seated in a wheel chair in the day room wearing a soiled hand splint on the right arm. A face-to-face interview was conducted with Employee #13 on August 4, 2008 at 3:20 PM. He/she acknowledged that the resident was not wearing a splint at that time. He/she added "[He/she] keeps removing the splint. I will call the doctor and let [him/her] know." The record was reviewed on August 4, 2008. 2. Charge nurse failed to apply a bed/chair alarm to Resident F4 as per the physician's order. A review of the physician's order sign and not dated February 2008 directed, "Personal [name] alarm while in bed and out of bed in chair for safety." as conducted. There were no bed and/or chair alarms observed in the resident's room or on the resident's wheel 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 9/18/08 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 24 A face-to-face interview was conducted on August 8, 2008 at 7:44 AM with Employee # 11. He/she acknowledged that the bed and/or chair alarm was not on the resident's wheel chair or in the room. The record was reviewed on August 8, 2008. C. Based on observations and staff interview for two (2) of # 2 dressing changes, it was determined that proper infection control procedures were not followed to prevent infection during pressure ulcer treatments. Residents #1 and 6. The findings include: On August 5, 2008 at approximately 12:10 PM a pressure ulcer treatment was observed for Resident #1. A physician's telephone order dated August 4, 2008, directed, "Cleanse sacral wound with wound cleanser, pat dry, apply Hydrogel ointment and cover with Allevyn dressing daily. Reevaluate in 14 days." Employee #11 entered Resident #1's room with a container filled with wound care supplies for all the residents on his/her assigned care team. Employee #11 used hydrogel (wound care treatment medication) labeled for another resident. At the completion of the treatment, the soiled dressing was discarded in a plastic bag which was closed, removed from the resident's room and placed in a biohazard container in the dirty utility room. Employee #11 failed to wash his/her hands in the dirty utility room. He/she went around the unit to	L 052	1. Resident #1 and #6 The nurses were educated on infection control practices for dressing change and proper use of treatment products. 2. All residents who have wounds have the potential to be affected by the deficient practice. Each nurse having a resident with a wound was observed doing a dressing change 3. All licensed staff will be required to pass a competency for dressing change yearly and as needed as issues arise The current licensed staff will be monitor for the next 30 days for compliance with infection control and the dressing change process by the Staff Development Coordinator./designee. The competency will be the tool used to measure the nurses strengths and weaknesses in the infection control process.	

PRINTED: 09/12/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING ____ B. WING ____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 26 [illegible] treatment basket was then removed from Resident #1's room and returned to the supply room. D. Based on observations and staff interview for [illegible] failing to wash his/her hands [illegible] treatment [illegible] labeled for another resident's use, failing to wash his/her hands [illegible] after discarding the trash bag containing the soiled dressing from Resident #1, [illegible] failed to clean the carrier containing wound care supplies after removing it from the resident's room. He/she said, "We will purchase baskets for each resident's wound care supplies [illegible] telephone order dated August 4, 2008, directed, "Cleanse sacral wound with wound [illegible] right heel, left heel and right shin. Employee #14 [illegible] prior to beginning the procedure but failed to cleanse the over bed table prior to using it. The employee tore two pieces of paper towel from the towel dispenser in the bathroom. He/she placed the two pieces of paper on the table and placed the dressing change supplies on top of the paper. [illegible] the treatment, the soiled dressing was discarded in a plastic bag which was [illegible] placed the bag [illegible] utility [illegible] resident's over bed table. The employee removed the bag and placed it in the soiled utility room but failed to clean the over bed table after its use. [illegible] the dirty utility room. He/she went around the unit to wash his/her hands in the medication room. [illegible] A face-to-face interview was conducted with the employee at approximately 9:45 AM on August 6, 2008. He/she acknowledged that he/she did not clean the table after using it and added, " I	L 052	Treatment Carts will purchase to insure each resident has their own labeled supplies Newly hired employees will have to pass a infection control competency that will include dressing change. The Staffing Coordinator will educate all nursing staff on the infection control process. 4. 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. 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.	8/30/08 ongoing 10/2/08 9/18/08 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 27 A face-to-face interview was conducted on August 7, 2008 at approximately 1:15 PM with Employee #11. He/she acknowledged: using hydrogel (wound care treatment medication) labeled for another resident's use, failing to wash his/her hands immediately after discarding the trash bag containing the soiled dressing from Resident #1, and using and failed to clean the carrier containing wound care supplies after removing it from the resident's room. He/she said, "We will purchase baskets for each resident's wound care supplies from now on." 2. On August 6, 2008 at approximately 9:15 AM a dressing change was observed on Resident #6's right heel, left heel and right shin. Employee #14 washed his/her hands prior to beginning the procedure but failed to cleanse the over bed table prior to using it. The employee tore two pieces of paper towel from the towel dispenser in the bathroom. He/she placed the two pieces of paper on the table and placed the dressing change supplies on top of the paper. Upon completion of the procedure, the employee placed the bag with soiled dressings on the resident's over bed table. The employee removed the bag and placed it in the soiled utility room but failed to clean the over bed table after its use. A face-to-face interview was conducted with the employee at approximately 9:45 AM on August 6, 2008. He/she acknowledged that he/she did not clean the table after using it and added, " I always clean it off, but I was nervous because I knew you were watching me. " E. Based on observations, record review and	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 28 staff interview for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to provide appropriate treatment for incontinence. Residents #2 and A3. The findings include: 1. Nursing staff failed to provide incontinent care to Resident #2 in a timely manner. 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. At 10:10 AM on August 6, 2008, Employee #3 was taken over to the resident. He was told that the resident needed to be changed and that the splint needed to be cleaned. Employee #3 responded "I will get the assigned CNA (Certified Nursing Aide) to take care of [him/her]." Employee #3 returned approximately five (5) minutes later and stated "I told the CNA. [He/she] is taking care of another resident and will come as soon as [he/she] is finished." At 10:50 AM, 40 minutes later Employee # 3 returned and stated "I went to check on the CNA. [He/She] is still with the other resident. I reminded [him/her] to come and take care of this resident when [he/she] is finished over there. " At 11:20 AM Employee # 8 walked over to the resident and proceeded to wheel him/her out of the room. When asked where he/she was taking the resident, the employee responded, "I am going to change [him/her]." At 11:35 AM, Employee #8 wheeled the resident	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 29 back into the day room. The record was reviewed August 6, 2008. 2. Nursing staff failed to provide timely incontinence care for Resident A3. The resident was observed seated in wheelchair in the day room on August 7, 2008. At approximately 12:30 PM, the resident was observed wet with a strong urine odor bilaterally from the thighs to the waist. Approaches and intervention for an "Incontinence Care Plan" [related to recent decreased mobility] dated June 30, 2008 indicated: "Toilet every two (2) hours and as needed to decrease number of incontinent episodes. Keep resident dry, especially after each episode of incontinence." A face-to-face interview was conducted with Employee#10 on August 7, 2008 at approximately 12:30 AM. He/she said, "I am taking the resident back to [his/her] room now to provide incontinence care." Employee #10 acknowledged that the resident was last provided incontinent care in the morning, before breakfast at approximately 8:30 AM. The record was reviewed on August 7, 2008.	L 052	1. The main kitchen trash was emptied. The trash was removed around the trash compactor 2. All trash receptacles were checked to insure they were not overflowing and had a lid on top 3. The kitchen supervisor will add to the daily kitchen check trash receptacles to insure the trash is properly disposed of. Educate the kitchen staff on the proper disposal of garbage and refuse. The Maintenance Supervisor will add to the daily check the compactor to insure the trash a round the compactor is picked up. 4. The Supervisors for the kitchen and Maintenance will present to the QA Committee the systemic changes made to insure the deficient practice does not reoccur. The Supervisors will present findings of the audits looking at trend and areas of noncompliance. The	
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 waste as required by State law.	L 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 106	Continued From page 30 The findings include: A tour of the main kitchen was conducted on August 4, 2008 between 8:45 AM and 12:00 PM, dietary staff was observed disposing of food and paper waste in a trash receptacle. It was further observed that food, paper and metal waste were disposed of in the same trash receptacles. Employee #27 acknowledged the above findings at the time of the observation and stated that there were two (2) working garbage disposals in the kitchen.	L 106	QA Committee will make recommendations for corrections to the plan of correction. Expired meds 1. 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. 2. All med rooms and med carts were checked to insure there were no expired or discharge meds in the carts. 3. In discussion with the pharmacy we will no longer be using the interim boxes due to in inhouse Omnicell.	
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation of two (2) of three (3) medication rooms, and staff interview it was determined that the facility staff failed to remove expired medication from currently dated medications, replace emergency box and date and initial four (4) of seven (7) multi-dose medication vials when first opened. The findings include: 1. The charge nurse failed the remove expired medication from currently dated medication from the IV Interim Infusion box, the Oral/ Injection Interim box , the cabinets in medication rooms and a medication cart. Facility's policy 5.3, Sec. 3, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" stipulated " The Facility should ensure that drugs and biological that: (have an	L 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 31 expired date on the label: ... are stored separate from other medications until destroyed or returned to the supplier." On August 6, 2008, between 8:15 AM and 11:30 AM, the facility's medication storage areas, which included the IV Interim Infusion box, the Oral/Injection Interim Box, medication room cabinets, the medication refrigerator and carts were inspected on each unit. A. The IV Infusion Interim box's expiration date of January 2008 was on the outside of the box. The box was located in the upper level medication room. Upon opening the interim box the following injections and IV fluids were found expired: Quantity Description Expiration Date 1 Methyl prednisone 125 mg vial 1/2008 4 Nafcillin 1 gm vial 1/2008 2 Sterile Vancomycin 1 gm vial 7/1/2008 3 Clindamycin 900mg/6 ml vial 11/1/2007 2 Sterile Water 20 ml Vial 6/162008 3 Ampicillin Sublactam 1.5 gm vial 6/2008 3 Unasyn 1.5 gm vial 4/1/2008, 10/1/2007 (2) 3 Promethazine 50 mg/ml vial 10/2007 3 Zosyn 2.25 gm vial 3/2008, 5/2008 (2) 2 Tazicef 1 gm vial 7/1/2008 1 50% Dextrose Injection %0ml Syringe 2/1/2008	L 161	The Omnicell will be updated to contain the same medications that were in the interim boxes and the interim narcotic box. Al list of medications is posted near the Omnicell All licensed staff will educated on how to use the Omnicell All licensed staff will be educated on dating open vials, returning discharge med, 5 rights of medication administration, proper handling of expired meds, All nurses will be educated to check every shift for expired medications and labeling and initialing when a new vial is opened. The 11-7 charge nurses on each unit will be responsible for checking the med carts and the med rooms for expired medications and disposing of them. The 11-7 Supervisor will do a random weekly audit of each med cart and med room to insure that there are no expired meds on the cart or in the med room, audit for unlabeled vials that have been opened and not initialed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 32 18 0.9% NaCl 5 ml filled syringes 6/2008, 5/2008 5 0.9% NaCl 100 ml IV bags 12/2007, 1/2008, 3/2008 1 10% Dextrose 1000 ml IV bag 7/2008 1 5% Dextrose IV bag 3/2008 1 KCl 20 mEq in Dextrose IV bag 3/2008 B. The following expired medications were found in the upper level cabinets : 2 Glutose 15 oral glucose gel tube 4/2008 25 Duo neb Ipratropium Br/Albuterol Sulfate 5/2008 100 Saline flushes 1/11/2008 The following medication was found in the lower level medication cart: 2 Lorazepam 0.5 mg tablets 8/3/2008 C. The inspection of the medication storage area on the lower level, included the Oral/Injection interim box. The box's expiration date of November 2007 was located on the outside of the box. Upon opening the Interim box the following medications were expired: Amoxicillin 250 mg 7of 10 tablets expired November, 2007 Duricef 500 mg, 6 of 6 tablets expired June 2008 Ciprofloxacin 250 mg, 5 of 5 tablets expired between April and June, 2008	L 161	The Consultant Pharmacist will continue to inspect the med rooms monthly and report any expired medications and unlabeled meds and assist in noting that the Emergency box has not expired and call the pharmacy for pick up. The med rooms and the med carts will be apart of the nursing weekly rounds with the DON , Unit manager, nursing assistant and the charge nurse . Weekly time 60 days then once a month. 4. The Don will present the systemic changes made to insure the deficient practice does not reoccur. The Don will review the audits looking at the trends and areas of noncompliance. The trends and the areas of noncompliance will be discussed by the QA Committee . The QA Committee will determine the effectiveness of the plan of correction make recommendations for corrections to the plan to insure consistent compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 33 Ceftriaxone 1 Gm vial, 1 of 4 vials expired May, 2008 Clonidine 0.1 mg, 11 of 11 tablets expired January through March, 2008 Aspirin 325 mg, 13 tablets expired between November 2007 and February 2008 Nitrofuranton 50 mg, 4 of 4 tablets expired between February and June, 2008 Lasix 20 mg, 6 of 12 tablets expired December 2007. Employees #14 and #15 were present during the inspection of the medication rooms. Both acknowledged the expired medications at the time of the above cited observations. A face-to face interview was conducted on August 6, 2008, at approximately 11:00 AM, with Employee #16. He/she stated that both interim boxes should have been returned to the pharmacy when the automated dispensing machine was installed. 2. The charge nurse failed to exchange the Emergency box. The facility ' s policy 6.6, Sec.6.1.1, " Interim/Stat/Emergency Supply of Medications, Exchange Drug Product Replacement System, and Emergency boxes " stipulated " Facility should ensure that emergency boxes remain on the nursing unit until either an item is withdrawn or one of its contents is about to expire. In either case, Facility should contact the Pharmacy for a replacement." On August 6, 2008, at approximately 9:30 AM, the upper level Emergency Box #832 was observed. The box was unlocked, and upon reviewing the withdrawal forms in the box, two	L 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 34 (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 161	1. Lorazepam and Mrophpine Sulfate were discarded. 2. The other med carts were checked for other medications that should be under lock and key or may stored improperly 3. The licensed staff will be educated on the proper handling and storage of controlled drugs (Schedule II) All license nurses will required every shift to check the med carts for medications that need to be under double lock and stored correctly according to spec. The 11-7 supervisor will audit the unit med carts weekly to insure controlled drugs are stored properly and medications that need to be stored in the refrigerator are stored correctly. A list of drugs and biological that must be stored in the a controlled temperature will be put in the MAR	
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 multi-dose 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 During a face-to-face interview, with Employees #14 and #16. They acknowledged that the vials listed above were not dated and/or initialed at the time of the observations.	L 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 183	3229.5 Nursing Facilities The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly, and revised as necessary. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff failed to write quarterly social service notes for Residents #4, #6 and #10. The findings include: A. Review of the clinical record for Resident #4 revealed that the record lacked evidence of a current quarterly social work notes. The last quarterly social work note on the record was dated April 11, 2008. 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 5, 2008. B. A review of the clinical record for Resident # 6 revealed that the record lacked evidence of a current quarterly social work note. The last quarterly social work note on the record was dated April 17, 2008. A face-to-face interview was conducted with Employee # 6 on August 7, 2008 A at approximately 4:00 PM. He/she acknowledged	L 183	Inspection of the med carts and med rooms will be part of the nursing rounds with the DON $. The DON will present to the QA Committee the systemic measure put in place to insure the deficient practice does no reoccur The Don will review the audits looking for trends and area of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 183	Continued From page 36 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 6, 2008. C. A review of the clinical record for Resident #10 revealed that the record lacked evidence of a current quarterly social work note. The last quarterly social work note on the record was dated April 15, 2008. 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 183		
L 189	3230.5 Nursing Facilities The responsibilities of the director of the activities program or his or her designee shall include, but not be limited to, the following: (a)To provide direction and quality guidelines of the program (b)To develop and maintain a plan for the program and procedures for implementing the plan; (c)To plan and budget for the program, including the number and levels of employees to be hired and the equipment and supplies to be purchased; (d)To coordinate and integrate the program with	L 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 189	Continued From page 37 other resident care services provided in the facility and in the community; (e)To assist in the development of and participate in staff orientation and annual education programs for all staff in the facility; (f)To develop a written monthly activities schedule in a large print calendar that includes date, time and location of each scheduled activity; (g)To post the activities schedule on the first working day of each month at each nursing unit, at a height that can be clearly seen by residents in wheelchairs; (h)To assure that visually, hearing and cognitively impaired residents know about posted activities; (i)To assess the therapeutic activity needs and interests of each resident within fourteen (14) days of admissions; and (j)To participate in the development of an interdisciplinary care plan and reassess each resident's responses to activities at least quarterly after reviewing with each resident his or her participation in the activities program. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to provide quarterly Activities notes for Resident #4. The findings include: A review of the clinical record for Resident #4	L 189	1. Resident #4 will have a completed Activities note 2. The Activities Director will do a chart audit to insure all resident have a completed up to date audit. 3. The Activities Director will complete a monthly audit to insure a activity note is in place . (Quarterly note) 4. The Activities Director will present to the QA committee the systemic measure put in place to insure the deficient practice does not reoccur The Activities Director will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 189	Continued From page 38 revealed that the record lacked evidence of a current quarterly activities note. The last quarterly Activities note on the record was dated March 11, 2008. A face-to-face interview was conducted with Employee #5 at approximately 9:30 AM on August 6, 2008. He/she stated "The supervisor usually writes the notes. I am not the supervisor. I am only acting in that capacity." The record was reviewed on August 5, 2008.	L 189	6. Facility staff failed to dispose of food waste as required by state law. 1. Emergency food was obtained during the time of inspection. 2. These items are assigned a separate area in the Dry Storage Room. The Emergency Food is shelf stable but has a 6 month shelf life, the food will be utilized in the Café and replaced so that a constant supply of food is available. 3. The Disaster Plan for dining services is in place. All emergency food is assigned for use in a 3 day period. This food is on a separate inventory so that it is not included in the regular food supply. 4. The Food Service Director will audit the use and the inventory supply monthly. The Food Service Director will present the systemic changes to the QA Committee to insure the deficient practice does not reoccur. The Food Service Director will review the audits looking for trends and areas of noncompliance. The QA Committee will determine the effectiveness of the plan of correction and make recommendations to insure compliance.	
L 205	3232.3 Nursing Facilities Summaries and analysis of incidents shall be reviewed at least monthly by the Administrator or designee in order to identify and correct health and safety hazards and patterns of occurrence. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to maintain a three (3) day supply of non-perishable staples on the premises as required by state law. The findings include: A tour of the emergency food area was conducted on August 4, 2008 at 4:15 PM and the following was observed: one (1) case of tropical fruit, cranberry juice four (4) cases, approximately 3 cases of pudding cups, one (1) case of tuna fish. A face-to-face interview was conducted with Employee #27 at the time of the observation. He/she acknowledged the above findings at the time of the observation and stated, " We don't have enough food for three (3) days."	L 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 39	L 206		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 15 sampled residents and 11 supplemental residents, it was determined that the facility failed to ensure that all alleged violations of neglect or abuse and injuries of unknown source were investigated and reported to the State Agency. Residents: #2, #9, #13, #14, A3, F6, M3, M4, M6, M7, M8, M9, M10, M12 and M14. The findings include: 1. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #2. A review of Facility Incident /Accident reports revealed: July 14, 2008 at 11:30 AM; "[Resident #2] Dark purple bruise R arm 4cm X 3cm Noted cause unknown. " July 30 2008 at 12:00 Noon "[Resident #2] Skin tear noted on Right Nostril ...Cause unknown." There was no evidence that either injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and	L 206	1. Resident #14, M12 , M13, M14 M7 have been discharged. Residents #2, #9 #13, A3 F6 M3 M4 M8 M10 will be investigated to determine if the resident was abused and if disciplinary action is needed for staff involved and the incident report faxed to the DOH 2.. All incident reports dating back to August 11th to present involving injures of unknown origin will be investigated and reported to the DOH 3.Educate all staff on Abuse 4. Further education the licensed staff on their responsibility for investigating and reporting abuse and suspected abuse and about disciplinary action for the employee involved in abuse. Revise the Incident Report policy and procedures to include a receipt must be obtained when the incident report and DOH for is faxed to the DOH The DOH form attached to incident form must include interventions to keep the resident safe .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 40 #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 2. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #9. A review of the Facility Incident /Accident reports revealed: July 9, 2008 at 4:30 PM: "Resident skin tear noted on right upper arm." 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. 3. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #13. A review of Facility Incident /Accident reports revealed: June 28, 2008 at 5:00 PM: "Resident #13 was observed with bluish discoloration and swelling of right cheek. Bilateral upper arm and right forehead also noted with bluish discoloration. Cause unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State	L 206	The Care Plan must be updated by the licensed nurse with new interventions that prevent reoccurrence of the incident. The Incident Investigation Form must be completed and attached to the Incident Report . This Form does not go to the state. The interdisciplinary team will review incident reports at Stand Up meeting daily to insure new interventions are in place or if further investigation is needed Once the Incident Report is completed they are submitted to the DON for be audited. 4. The DON will submit to the QA committee the systemic measure put in lace to prevent the deficient practice from reoccurring. The DON will trend the incident reports looking at Patterns involving staff Diagnosis Mental Status Types of injuries Time of Day Need for training and other areas suggested by the QA Committee The QA Committee will discuss the trends and areas of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 41 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. 4. Facility staff failed to investigate an injury of unknown source for Resident #14 A review of Facility Incident /Accident reports revealed: May 1, 2008 at 1:30 PM: "Resident #14 was observed skin tear right elbow during lunch time. Origin 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. 5. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident A3. A review of Facility Incident /Accident reports revealed: June 24, 2008 at 10:00 PM: "While CNA was giving PM Care to Resident A3 a bruise on left upper arm 4cmX2cm and bruise Left hip 7cmX7cm was observed ,dark purple in color.	L 206	noncompliance , effectiveness of the plan of correction and recommend corrections to the plan to insure consistent compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 42 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 red...see 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 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 to monitor ... "	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not 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	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 44 revealed: July 29, 2008 at 8:30 PM, " ... bruise /abrasion on residents right lower arm; noted with skin tear on right arm with small amount of bleeding area cleansed and dressing applied." 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 incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 9. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M7. A review of Facility Incident /Accident reports revealed: May 12, 2008 at 2:40 PM, "... skin tear on right elbow possibly due to bed rail..." 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. 10. Facility staff failed to investigate an injury of	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 45 unknown source for Resident M8 A review of Facility Incident /Accident reports revealed: May 26, 2008 at 2:45 PM: "Resident...with bruise corner of right eye and nose bridge dark red ... unaware as to how it happened or what caused the bruise." May 28, 2008 at 1:30 PM: "Resident M8 was observed skin tear right lower extremity ...Not aware how it happened." There was no evidence that either injury of unknown source was investigated. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated. Employee #1 stated that both incidents were reported to the State Agency on May 27 and June 2, 2008 respectfully. The record was reviewed August 7, 2008. 11. Facility staff failed to investigate an injury of unknown source for Resident M9. A review of Facility Incident /Accident reports revealed: May 9, 2008 at 1:00 PM: "[Resident M9] was observed with skin tear right elbow ... Origin 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	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 46 #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. 12. Facility staff failed to investigate an injury of unknown source for Resident M10. A review of Facility Incident /Accident reports revealed: June 10, 2008 at 11:15 AM, "Resident ...with skin tear below right ankle measured 2cm X 2cm." 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. 13. Facility staff failed to investigate an injury of unknown source for Resident M12. A review of Facility Incident /Accident reports revealed: June 10, 2008 at 8:30 PM: "[Resident M12] was noted with skin tear right outer lower leg 1cm X ,5cm and 2cm X 1 cm with minimal bloody drainage June 16, 2008 at 7:50 PM: "Left hand and middle finger with dark bruise ...Etiology Unknown..."	L 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 48 reported ... noted skin tear on resident ' s left wrist while giving care." 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.	L 206		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled kitchen appliances, drains, compressor in the walk-in refrigerator, floors, wheelchairs/chairs/gerichairs; damaged and/or marred/scarred baseboards, walls, ceiling tiles, dusty and/or soiled medication rooms and carts. A tour of the main kitchen was conducted on August 4, 2008 from 8:45 AM to 11:45 AM in the presence of Employee #27 and the findings were acknowledged at the time of the observations. The environmental tour was conducted on August 5, 2008 from 11:20 AM to 3:30 PM and August 6,	L 410	L410 3256 Nursing Facilities Dietary A, B, C, D, E, F, G, H, I. J. K. L. M. N, O were all cleaned item G. The receptacle was replaced. Item C. Additional Hangers installed Item D Additional dunnage rack purchased and items removed from the floor during inspection 2. All equipment is on a daily cleaning schedules which included floors, drains, ice machines, walls. Utility workers are responsible for all equipment in the closet including mops, buckets and squeeges During deliveries all boxes will be delivered to the proper locations off the floor 3. Cleaning list includes a super visor check to be monitored weekly. The Food Director will complete a grand check monthly. Staff have been inserviced on the cleaning schedules Utility staff have been inservices	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 49 2008 from 9:40 AM to 10:20 AM in the presence of Employees #27 and 28. The findings were acknowledged at the time of the observations. An inspection of the facility's medication carts was conducted on August 11, 2008 between approximately 8:30 AM and 9:00 AM in the presence of Employees # 3, 14, 13 and 20. The findings were acknowledged at the time of observations. The findings include: 1. The following appliances and areas were observed soiled in the main kitchen and pantries on the health care unit(s): A. Gas stove in one (1) of one (1) stove observed; B. Double Convection ovens in two (2) of two (2) ovens observed; C. Deep fryer in one (1) of one (1) deep fryer observed; D. Double Steamer in one (1) of one (1) steamer observed; E. Broiler in one (1) of one (1) broiler observed; F. Hot box near stove in one (1) of one (1) hot box observed; G. Juice machine upper level pantry in one (1) of three (3) juice machines observed; H. Ice machine in the main kitchen and both pantries on the health care unit(s) in three (3) of three (3) ice machines observed; I. Tilt skillet soiled in one (1) of one (1) tilt grill observed; J. Drains in main kitchen near ice machine and the kettles in two (2) of two (2) observed; K. Soiled compressor in walk-in refrigerator in one (1) of one (1) observed; L. Floors in the main kitchen and floor in the	L 410	4. The Food Service Director will present the systemic changes made to the QA Committee for recommendations to insure the deficient practice does not reoccur. The Food Service Director will review audits/schedules looking at trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee . The QA Committee will determine the effectiveness of the plan of correction and make recommendations. to the plan to insure consistent compliance Housekeeping and Maintenance 1. PQA all ceiling tiles replaced. C. carpet in room 182 and 190 were replaced D. the two Geri Chairs have been cleaned F. the horizontal surfaces of the bed frames for rooms 41, 45, 71, and 80 G. The damaged bedside commode in 70 was discarded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 50 pantries were observed soiled; M. Refrigerator and freezer floors were observed soiled in eight (8) of eight (8) refrigerators and two (2) of two (2) freezers were observed; N. Kitchen floor mats were observed soiled in three (3) of three (3) floor mats observed; O. Soiled floor in beverage closet in one (1) of one (1) observed; P. The women bathroom/locker room was observed with solid ceiling tiles in one (1) of one (1) observed; Q. Ceiling tiles were stained/soiled in both pantries in the health care units; 2. Additional areas in the facility were observed as follows: A. Ceiling tiles were soiled in Rooms 43, rehab dining room, lower level day room and the rehabilitation gym B. In the Beauty Shop: Hair rollers stored for reuse observed with hair in five (5) of five (5) containers of rollers observed; C. Carpeting in five(5) of 26 rooms observed, rooms 41, 81, 88, 182 and 190, the linen closet and the corridor on rehabilitation unit were observed D. Chairs gerichairs and/or wheel chair were observed soiled in six (6) of six (6) observed rooms 80, 94 and 170 and three (3) in the lower level dining room in six (6) of 12 observed E. 0xygen concentrator filters were observed to soiled in two (2) of five (5) filters observed, rooms 170 and 88; F. Horizontal surfaces of bed frames in four (4) of 26 rooms observed, rooms 41, 45, 71 and 80; G. A bedside commode in room 70 was observed with a brown substance on the lid in one (1) of 26 rooms observed 2. The following items/areas were observed	L 410	A. The day room will have wall guards installed along the walls C The arms of the chairs in the first floor day room were cleaned. B The ceiling tiles will be replaced c. Damaged light fixture UL and missing light bulbs on LL level were replaced. D. The light repaired and cover replaced in the men bathroom E. The hole in the women's bathroom was repaired H. The rusted air vents were primed and painted I The lights in rooms 41, 43, 42, and 46 were placed K Night lights in room 71,72, 80, 81, 97 were replaced L. The damaged night stands were removed form room 190and the table and dresser were removed form 80 2. All areas of the Health Center will be audited for areas that need maintenance attention. 3. The Facilities manger, the Maintenance Supervisors will 4. make rounds weekly looking or opportunities for repairs. 5. The repairs will be documented on the Room and Space Inspection Form and will be submitted to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 51 marred/scarred: A. The day room walls in two (2) of three (3) day rooms observed. B. Walls were observed in four (4) of 26 rooms observed, rooms #42, 45, 46 and 97 C. Arm chairs in the first floor day room in seven (7) of seven (7) chairs observed, rehabilitation unit dining room six (6) of six (6) chairs 3. The following items/areas were observed damaged: A. The wall near the preparation sink and across from steam kettle was observed damaged in one (1) of one (1) wall observed in the main kitchen; the wall in the nursing station on rehabilitation unit was observed damaged; B. Ceiling tiles were missing/damaged in both pantries in the health care units, in the beverage closet in located in the main kitchen and in the laundry room; C. Damaged light fixtures: upper pantry damage light fixture, lower had missing light bulbs in two (2) of two (2) observed D. The men's bathroom/locker room for kitchen employees was observed with a non-functioning light and missing cover over the light. E. The women bathroom/locker room was observed with a hole in wall in one (1) of one (1) observed. F. Beverage closet had broken light cover in one (1) of one (1) observed G. The foot pedal of the trash receptacle in the upper pantry did not engage when pressed, and manual opening of the lid was required to dispose of trash in one (1) of two (2) trash receptacles on August 7, 2008 at 8:18 AM. H. Rusted air vent in the pot and pan wash area in one (1) of two (2) air vents observed; I. Lights were observed to be missing and/or not working four (4) of 26 rooms observed, rooms 41,	L 410	office to be placed on a work order form for repair. The Maintenance Supervisor will audit the Room and Space inspection form weekly by making rooms t insure items have been repaired Cleaning Schedules will be established for carpets to be cleaned daily . The Housekeeping Supervisor will make rounds daily and document on the Housekeeping rounds list the carpets that have been cleaned. The med carts will be included in the Housekeeping daily cleaning schedule. Wheel chairs will be cleaned daily by room number one each unit. The wheel chair schedules will be posted on the units. The Housekeeping Supervisor will do a weekly audit to insure the wheelchairs are being cleaned. 4. The Director of Facilities will present the systemic measures to the QA committee for recommendations to insure the deficient practice does not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 52 43, 42 and 46; J. An arm rest was observed to be damaged on one (1) of one (1) bedside commode observed in room 70; K. Night lights were not in working six (6) of 26 rooms observed, rooms 71, 72, 80, 81, 88 and 97; L. In two (2) of 26 rooms observed the following was damaged: Night stand and missing drawer was observed to be damaged in 190 and a table stand missing a leg and a missing knob on dresser in room 80; 4. The following items were observed stored on floor(s): A. The linen closet on the rehab unit was observed to have approximately two (2) air mattresses stored on the floor of the closet B. Four (4) of four boxes were observed stored on the floor in the electrical closet on the lower level and one (1) of one (1) box was observed on the upper level C. Brooms were observed stored on the floor in the janitor ' s closet in the main kitchen two (2) of three (3) brooms observed. D. Boxes of dishes stored on floor in the dry storage area in six (6) of six (6) boxes observed. 5. Medication rooms: Medication room floors were observed soiled in two (2) of two (2) medication rooms observed on August 6, 2008 at approximately 8:30 AM. 6. Medication carts were observed soiled: Four (4) of four (4) medication carts were observed soiled with dirt, dust and spilled medications both inside and outside.	L 410	The Director of Facilities will review the schedules and audits looking for trends, and area of noncompliance. The trends and areas of noncompliance will be discussed by the QA committee . The QA committee will determine the effectiveness of the plan of correction and make recommendations for correction to the plan to insure consistent compliance. 6. Medication carts – New medication carts were obtained . All the nurses will be required to clean their carts after every shift. They will be monitored on the nursing weekly rounds. !!07 will do a though cleaning every Wednesday.	
L 999	DC CODE	L 999		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 999	Continued From page 53 This Statute is not met as evidenced by: following nurse's note dated July 11, 2008 at 10:00 PM, "Resident moved from [room number] to [room number]." There was no evidence in the record that the physician was notified of the resident' s relocation. B. On August 4, 2008 at 9:38 AM, Resident P1 stated, " I just moved. I don't like my room." A review of Resident P1's record revealed a nurse's note dated July 19, 2008 at 11:00 PM, " ... [Resident P1] was transferred from [room number] to [room number]." There was no evidence in the record that the physician was notified of either resident's relocation. A face-to-face interview with Employee #12 was conducted on August 7, 2008 at 9:15 AM. He/she stated, "Both residents were moved to different rooms. I notified their families. I didn't know that I needed to notify the physician." The records were reviewed August 4, 2008.	L 999	1. #P1 This resident has never been transferred. 2. #JH2 The physician was made aware of the transfer 3. #3 The family was made aware 2. Review of the census will identify other residents who have had a room change. Once identified the family and physicians have been notified. 3. The Social Worker will develop a room change policy Initiate the DC 6108 Form for all facility room changes Educate the licensed staff on the Dc 6108 and the Room Change policy and procedure The licensed staff will initiate the DC6108 , notify the MD, Family and or responsible party and document this information in the medical record The room change must be documented on the 24 hour report. 4. The Social Worker will audit the census daily for occurrences of room changes and insure there is a completed Dc 6108	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	08/11/2008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 999	Continued From page 54 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 physician for two (2) residents. Residents #3, P1, JH2. The findings include: 1. Facility staff failed to notify Resident #3's responsible party when he/she was relocated to another room within the facility. 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..." There was no evidence in the resident's record that the responsible party was informed of the aforementioned resident's room change order. A 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 responsible party was notified when the resident changed rooms. The record was reviewed August 5, 2008 2. Facility staff failed to notify the physician when Residents JH2 and P1 were relocated within the facility. A. Review of Resident JH2's record revealed the	L 999	☐ 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 corrections to the plan to insure consistent compliance.	Ongoing