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 ______	09/10/2009

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 at your facility on September 8 through 10, 2009. The following deficiencies were based on observations, staff interviews and record review. The sample size was 15 residents based on a census of 62 residents on the first day of survey.	L 000	Ingleside at Rock Creek is filing this plan of Correction for purposes of regulatory compliance. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and	L 052	Resident # 7 had all labs drawn per Physician orders. Her record was reviewed to make sure it was noted on Physician order sheet correctly and in the TAR(treatment administration record.) Resident #8 is receiving his medication as ordered. Resident #10 order was re-written so that the staff had parameters to work with. Staff are documenting the pulse ox in the TAR(treatment administration record). Charts were audited to make sure that ordered labs were done and on the medical record. The lab book continues to be checked daily to make sure all labs have been drawn and if a resident refuses that Physicians are notified. The TAR were audited to make sure pulse ox % were documented. Resident's who receive oxygen records were checked to make sure they were correctly written to address the monitoring of pulse ox %. Corrections were made where needed. The nurse who failed to document per facility policy and procedure was counseled and provided with additional education. He was also re-inserviced on the correct way to administer medication, including signing the MAR(medication administration record) when med is given. Nursing management will do random med pass audits with this nurse focusing on signatures and continue to do random med pass audits with all nursing staff. Licensed nurses were re-inserviced on facility policy regarding writing orders with parameters and monitoring them,	11/15/09 Begun 9/11/09 Completed 11/15/09

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ann R. Schiff | TITLE: Administrator | (X6) DATE: 10/12/09

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 ______	09/10/2009

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 1 (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and interview for three (3) of 15 sampled residents, it was determined that sufficient nursing time was not given to residents to: obtain laboratory studies as ordered by the physician for one (1) resident, administer medication in accordance with the physician's orders and failed to follow through with physical therapist's recommendations for a functional maintenance program for ambulation for one (1) resident and clarify orders for oxygen saturation levels for one (1) resident. Residents #7, 8 and 10. The findings include: 1. Sufficient nursing time was not given to Resident #7 to obtain laboratory (lab) studies for Resident #7 as ordered by the physician. A review of Resident # 7's clinical record revealed an "Interim Order Form" dated June 8, 2009 signed by the physician and renewed July 30, 2009 that directed the following: "CBC (Complete	L 052	monitoring pulse ox% in the correct place, and using the lab log so that residents who are refusing are rescheduled and physicians have been made aware. Nursing Management will continue with their random chart, MAR/TAR and lab log audits for compliance. Any issues will be brought to the QI monthly meeting for evaluation and intervention.	9/14/09

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 ______	09/10/2009

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 2 Blood Count)...next lab [Laboratory] day and q [Every] 3 months Sept/Dec/ March/June. TSH (Thyroid Stimulating Hormone) next lab day and q 6 months June/Dec. " According to the resident's June 2009 MAR [Medication Administration Record], an entry on June 10 and 12, 2009, indicated " Refused " for " TSH, CBC. " There was no evidence in the record that the TSH and CBC lab studies had been obtained for Resident #7 at the time of this review. A face-to-face interview was conducted with Employee #3 on September 9, 2009 at approximately 12:30 PM. After reviewing the resident's clinical record, Employee #3 acknowledged the aforementioned findings. He/she stated: "The resident refused the blood draw on the next scheduled lab day as ordered and it was not followed up with. I have to renew the order and schedule another blood draw for tomorrow." The record was reviewed September 9, 2009. 2. Sufficient nursing time was not given to administer medication in accordance with physician orders and failed to follow through with physical therapist's recommendations for a functional maintenance program for ambulation for Resident #8. A. Physician's order dated July 13, 2009, directed, "Coumadin 8 mg tabs by mouth every evening for Deep Vein Thrombosis prophylaxis." A review of the September 2009 Medication Administration Record (MAR) revealed that Coumadin was scheduled to be administered at 9	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 ______	09/10/2009

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 3	L 052		

PM every evening. The spaces allotted for Coumadin administration on September 7 and 8, 2009 were blank, reflecting the medication was not administered. The record lacked evidence of the reason why the medication was omitted.

A face-to-face interview was conducted on September 9, 2009 at approximately 10:00 AM with Employee #4. He/she acknowledged that the blank spaces on the June 2009 MAR revealed that Coumadin was omitted on September 7 and 8, 2009. He/she contacted the physician for directives.

A face-to-face interview was conducted with Employee #14 September 10, 2009 at approximately 3:00 PM. He/she acknowledged that on September 7 and 8, 2009 his/her signature was omitted from the MAR. He/she stated that the medication was given, but he/she forgot to sign the MAR.

The medical record lacked evidence of Resident #8 receiving scheduled medication in accordance with the physician order and lacked documentation indicating why the Coumadin was not given. The record was reviewed on September 9, 2009.

B. Sufficient nursing time was not given to Resident #8 to follow through with physical therapist's recommendations for a functional maintenance program for ambulation

Resident #8 was residing in the independent apartments of the facility and subsequently sustained a fall and fractured hip. The resident was admitted to the facility January 26, 2009.

According to Section G (Physical Functioning and

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 ___	09/10/2009

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 4 Structural Problems) of the quarterly Minimum Data Set assessment signed June 28, 2009, the resident was coded as requiring limited assistance of one person for locomotion, self propelled wheelchair as primary mode of locomotion and and used a walker. According to the most recent physical therapy care plan, rehabilitation services were provided July 22 through August 19, 2009 for gait training and therapeutic exercises. Review of the resident ' s record revealed that a PT " Weekly Progress Note " dated August 20, 2009, that directed, " ...arrange with caregiver to rolling walk patient for ambulation training maintenance program; discontinued from skilled PT to functional maintenance program for ambulation " . There was no evidence in the resident's record that the functional maintenance program for ambulation was developed. A face-to-face interview was conducted on September 9, 2009 at approximately 12:40 PM with Employee #4. He/she acknowledged that functional maintenance program for ambulation was not developed. Employee #4 stated that, " I see him walked on a regular basis " . A face-to-face interview was held with the Employee #17 on September 9, 2009 at approximately 12:47 PM. He/she acknowledged that the caregiver was trained to assist Resident #8 on a functional maintenance program for ambulation. The medical record lacked evidence that a functional maintenance program for ambulation	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 ____	09/10/2009

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 5 was developed per Physical Therapist recommendations. The record was reviewed on September 9, 2009 3. A review of the clinical record for Resident #10 revealed sufficient nursing time was not given to clarify a physician's orders for the assessment of oxygen saturation levels. Resident #10 was admitted to the facility March 28, 2008 and diagnoses included COPD (chronic obstructive pulmonary disease). Physician's orders dated September 2, 2009 directed, "O2 (oxygen) at 2L/min via nasal cannula as needed for shortness of breath and to maintain O2 sats (saturations) > 93%." The physician's order lacked evidence of monitoring parameters to be utilized in order to maintain the resident's O2 sats greater than 93%. A face-to-face interview was conducted with Employee #4 on September 9, 2009 at approximately 3:00 PM. He/she stated that licensed staff assessed the resident's O2 saturation via pulse oximetry every shift. He/she acknowledged that the record lacked evidence of scheduled pulse oximetry assessments and that the physician's orders lacked monitoring parameters. The record was reviewed September 9, 2009.	L 052		
			L 091 The infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. Resident #13 no longer resides at the facility. Prior to her discharge her nares cultures came back negative and she was removed from isolation. Employee #10 was re-inserviced on infection control. Her inservice records showed she had attended the many inservices given on infection control. Staff development will continue inservicing the entire staff during his , "focus" reviews on infection control.	11/15/09
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control,			

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 ____	09/10/2009

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 091	Continued From page 6 laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff removed trash from an isolation room. The findings include: Resident #13 was admitted to the facility on September 2, 2009. According to the admission orders signed by the physician on September 4, 2009, " Contact isolation for MRSA in nares. " According to a physician ' s order dated September 4, 2009, "Bacitracin ointment apply to nares BID (twice daily) x 14 days (MRSA colonization)." A culture of the nares is scheduled for September 21, 2009 to determine the isolation status of the resident. On September 9, 2009 at 10:10 AM, Employee #10 was observed removing a plastic bag of trash from Resident #13's room, walked down the hallway and disposed of the trash in the soiled utility room. A face-to-face interview was conducted with Employee #10 at the time of the observation. He/she acknowledged that trash should not have been removed from the isolation room in the manner he/she had done. The record was reviewed on September 9, 2009.	L 091	Who remains on isolation. We changed out infection control manual to include having a red bag in a resident's room who are on contact isolation. The red bag trash will be taken to the soiled utility room and placed in the red bio waste container. Any new resident put on contact isolation will have someone from nursing management make sure that the room is set up to meet CDC guidelines. Staff Development will continue to include infection control on their focused inservice list and will also continue to have it as part of the orientation program. Nursing management continues to always observe for compliance with facility's infection control policy and do one and one training immediately when non-compliance is observed. If any issues are identified they will be brought up at the monthly QI meetings for evaluation and intervention.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set	L099	Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B,D.C. Municipal Regulations (DCMR), Chapter 24-40. 1. five drains will be fixed, by 10-30-09 to prevent back flow in the event of a sewer back up. The air gap space was corrected. 2. The filter soiled with debris in the ice machine was replaced by contractor and	10/30/09

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 ______	09/10/2009

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 099	Continued From page 7 forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during a tour of the main kitchen and upper and lower level pantries, it was determined that facility staff failed to: properly position five (5) of five (5) water supply outlets (drains) from equipment to prevent backflow in the event of a sewer back up, clean the filter on one (1) of one (1) ice machine in the main kitchen and use the correct serving scoop size for one (1) luncheon item and list portion size on the production sheet for two (2) items. The kitchen tour was conducted on September 8, 2009 from 10:00 AM through 12:10 PM and 12:30 PM through 1:15 PM in the presence of Employee #6. The findings include: 1. Five (5) of five (5) drains from equipment and sinks were not properly positioned over floor drains to prevent back flow in the event of a sewer back up. There was no air gap space to separate the water-supply outlet (drain) from a potentially contaminated source. 2. One (1) of one (1) ice machine in the main kitchen was observed with a filter soiled with debris. 3. On September 8, 2009 at 12:45 PM, the lunch meal was observed on the Lower Level. According to the production sheet for chopped meat the portion size was 4 ounces and a 6 ounce scoop was used. According to the production sheet the portion size for scallops was four (4) pieces. Two (2) scallops	L 099 L 099	Will be cleaned by maintenance routinely.. 3. Kitchen serving staff were reinserviced on scoop sizes and why it's important to use the correct scoop size. Portion size was also discussed. Kitchen managers have and will continue to audit serving staff to make sure they adhere to portion size by following the production sheets. Production sheets are audited to make sure staff are following the correct portion size. If a portion size is omitted the Dietary management will correct the omission. During Dietary orientation of new employees they have added the inclusion of portion size and which scoop should be used. Any issues found will be brought to the monthly Quality Assurance meeting for evaluation and interventions as needed.	11/15/09

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 ______	09/10/2009

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 099	Continued From page 8 were served. Employee #16 stated at the time of the observation, " Four small scallops are served or two big ones. These are big scallops so I will serve only two. " The portion size for pureed bread was not listed on the production sheet. Employee #16 stated at the time of the observation, " The pureed bread is for residents who can't chew the hard rolls. We serve four ounces of pureed bread. " An 8 oz. scoop was used. Employees #6 and 16 acknowledged the findings at the time of the observations.	L 099		
L 183	3229.5 Nursisng 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 one (1) of 15 sampled resident records, it was determined that the social worker failed to conduct a quarterly assessment for Resident #4. The findings include: A review of Resident #4's record revealed that the last social worker's note was dated May 8, 2009. There was no evidence in the record that the social worker documented in the resident's record subsequent to that assessment. A face-to-face interview was conducted with Employee #5 on September 8, 2009 at approximately 3:30 PM. He/she acknowledged the lack of social work notes scheduled for	L 183	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. Resident # 4 no longer resides at the facility. We reviewed the MDS schedule to make sure that no resident is omitted. The reason there were no quarterly notes from activities and social services was related to the coding error of our previous MDS coordinator. We hired a new RN MDS coordinator who audits the resident schedule for MDS routinely to make sure that a resident was coded correctly so that their assessment will not be missed. The audit did not find any date inconsistencies. The RN MDS coordinator will be provided with education and support to make sure that the facility stays compliant with this tag.	10/30/09

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 ______	09/10/2009

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 9 August 2009. The record was reviewed on September 8, 2009.	L 183	We will continue to monitor for any inconsistencies and these concerns will be brought to the QI monthly meeting for evaluation and intervention.	
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 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;	L 189	Resident # 4 no longer resides at the facility. We reviewed the MDS schedule to make sure that no resident is omitted. The reason there were no quarterly notes from activities and social services was related to the coding error of our previous MDS coordinator. We hired a new RN MDS coordinator who audits the resident schedule for MDS routinely to make sure that a resident was coded correctly so that their assessment will not be missed. The audit did not find any date inconsistencies. The RN MDS coordinator will be provided with education and support to make sure that the facility stays compliant with this tag. We will continue to monitor for any inconsistencies and these concerns will be brought to the QI monthly meeting for evaluation and intervention.	10/30/09

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 ______	09/10/2009

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 10 (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. Based on record review and staff interview for one (1) of 15 sampled resident records, it was determined that the Activities Coordinator failed to conduct a quarterly assessment for Resident #4. The findings include: A review of Resident #4's record revealed the last documented activity progress note was dated May 13, 2009. There was no evidence in the record that the activities coordinator documented in the resident's record subsequent to that assessment. A face-to-face interview was conducted with Employee #15 on September 8, 2009 at approximately 3:45 PM. He/she acknowledged that there was no activity progress notes since May 13, 2009. The record was reviewed on September 8, 2009.	L 189		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the	L 410	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.	11/15/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0008	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/10/2009
NAME OF PROVIDER OR SUPPLIER: INGLESIDE AT ROCK CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE: 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 11 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 environmental tour, it was determined that facility staff failed to: ensure that a rubber gasket was secure on one (1) of one (1) bath tub, mount five (5) of five (5) multiplugs on the wall and dispose of 50 of 50 boxes of an expired nutritional supplement. The environmental tour was conducted on September 8, 2009 at 2:00 PM through 3:30 PM in the presence of Employees #3, 4, 7 and 8. The findings include: 1. The bath tub on the upper level was observed with the rubber gasket unattached around the base of the tub in one (1) of one (1) tub observed. 2. Multiplugs were observed on the floor and not mounted on the wall in rooms 44, 45, 70, 176 and 184 in five (5) of five (5) multiplugs observed. 3. 50 of 50 containers of a nutritional supplement were observed with an expiration date of January 1, 2009 in the upper level storage room across from the nurse's station. These findings were acknowledged by Employees #3, 4, 7 and 8 at the time of the observations.	L 410	1. The missing gasket will be repaired by October 39,2009. 2. The Multiplugs noted in rooms 44,45,70,176 and 184 have been mounted on the wall. 3. Expired supplements were thrown away. We don't use that supplement in the facility. Rooms were checked for multiplugs resting on floor. The ones that were identified will be mounted to wall. Supplements come to the central supply and they were audited for expired dates. None were found. During routine room rounds by maintenance they have added the multiplugs to there audit. Any non-compliant plugs found will be fixed appropriately. Central supply staff will routinely check for expiration dates when supplements are stocked and will discard any supplements that are not used in the facility. Any issues will be brought to the monthly Quality Improvement meeting for evaluation and interventions.	10/30/09