		HAND HUMAN SERVICES				FORM	10/13/2006 APPROVED
STATEMENT		K     MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLE	
		095028	B. WI	NG	<u>Filmenter</u>	10/0	6/2006
NAME OF P	ROVIDER OR SUPPLIER					1 31,0	2006
INGLESI	DE PRESBYTERIAN	RETIREM			NASHINGTON, DC 20015	(A, ~ )	din
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE C	BE CROSS-	(X5) COMPLETION DATE
F 000 F 241 SS=D	An annual recertific October 4 through deficiencies were b reviews and staff ir included 15 resider residents on the fir supplemental resid 483.15(a) DIGNITY The facility must pr manner and in an e	cation survey was conducted 6, 2006. The following based on observations, record hter⊽iēws. The sample hts based on a census of 68 st day of survey with one (1) ent.		241	F 241 It is the policy of Ingleside processes of residents in a manner an environment that maintair enhances each residents dign respect in full recognition of her individuality. Corrective Action for Affect Residents: 1. Resident # 12 was redresses immediately at the time of th	and in as or ity and his or <b>ted</b> ed	
	This REQUIREMENT: Based on observat 1) of 15 sampled re- that facility staff fail dignity as evidence exposure of the res The findings includ Resident #12 was of at 3:30 PM sitting in with seven (7) othe #12's dress was too down the side sear inches above the h no undergarments abdominal area and exposed.	is or her individuality. NT is not met as evidenced by ion and staff interview for one ( esidents, it was determined led to maintain Resident #12's id by failure to prevent sident in the dayroom. e: observed on October 4, 2006 in a wheelchair in the dayroom r residents present. Resident rn from under the left arm in to approximately three (3) em. The resident was wearing and the left upper torso, d left upper thigh were			survey. 10/06/2006 Procedure for Identifying Potentially Affected Reside 2. The Nursing Assistant's ar required to check all resident clothing and apperance to ins that they are appropriate for t environment. 10/04/2006 Measures Adopted for Syst Change: 3. The Nursing Staff will educated on the dignity o residents in regards to dre and appearance. Unit Managers will do rot on the floor weekly. Check for residents clothing will include in those rounds. 11/19/2006	re s sure he <b>emic</b> be re- f essing unds king	
BORATOR		DE LASURA DE LE UN PEL STRATATOR STRAT	ATURE	/		1	(X6) DATE
	Rena /	1X Just	Alt	11	Vistanton 1	0/27/1	6

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days towing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 sys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

		2023530950 H AND HUMAN SERVICES E & MEDICAID SERVICES	ING	IGLESIDE AT ROCK CR PAGE 02/09 PRINTED: 10/13/2006 FORM APPROVED IN OMB NO. 0938-0391
STATEMENT AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	
		095028	B. WING	IG10/06/2006
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESI	DE PRESBYTERIAN	RETIREM		3050 MILITARY ROAD NW WASHINGTON, DC 20015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL .SC IDENTIFYING INFORMATION}	ID PREFIX TAG	C - Hall
F 241	out of bed at 3:45 see the torn part o changed it."	PM. He/she stated, "I didn't f the dress or I would have	F 24	and Quality Assurance:4. For the next 90 days, Unitmanagers will present thefinding of their weekly roundsto be monitored by the Quality
F 253 SS=E	The facility must p maintenance servi sanitary, orderly, a	SEKEEPING/MAINTENANCE rovide housekeeping and ces necessary to maintain a nd comfortable interior.	F 25	<ul> <li>Assurance Committee Monthly. (November, December and January) Starting 11/06/2006.</li> <li>F253 Housekeeping and Maintenance</li> </ul>
	Based on observal it was determined maintenance servi ensure that the fac and sanitary mann wheelchairs, exhan Sonozaire deodori in the garage arou surfaces in the sm slats at the entrand wall surfaces in the outside of the main dining room chairs bathroom doors. T the presence of ma nursing staff. The findings includ 1. The wheelchairs in the Garden Leve spoke and frame s and debris in five ( 12:20 PM on Octol	that residents were sitting on al dayroom were soiled on the urfaces with accumulated dust 5) of eight (8) observations at ber 4, 2006.		<ul> <li>Corrective Action for Affected Residents:</li> <li>1. All wheelchairs observed were cleaned and completed by 10/29/06</li> <li>The interior surfaces of exhaust vent identified will be cleaned and completed by 11/05/06.</li> <li>The Sonozaire deodorizer located in the garage near the trash dumpster was cleaned and completed 10/25/06.</li> <li>The paper and soiled products observed on the floor and surrounding areas of the trash dumpster in the garage were cleaned and completed on 10/06/2006.</li> <li>The floor and surrounding areas of the small laundry</li> </ul>
enin de la Pr	497 (197-199) Else cinwes Versaam	,7∰esodo - Esono Eso	12-05	room observed to be soiled at Page 2 of 2° were cleaned and completed by 10/25/06.

1	RS FOR MEDICARE & MED			GLESIDE AT ROCK CR
		VIDER/SUPPLIER/CLIA	(X2) MU A. BUILI	
		095028	B. WINC	NG10/06/2006
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESI	DE PRESBYTERIAN RETIREM	Λ		3050 MILITARY ROAD NW WASHINGTON, DC 20015
(X4) ID PREFIX TAG	SUMMARY STATEMENT ( (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTI	PRECEEDED BY FULL	ID PREFIX TAG	
F 253	Continued From page 2 Lower Level dayroom in se	ven (7) of nine (9)	F 25	completed 10/06/2006.
	observations between 2:25 October 5, 2006.	PM and 3:45 PM on		• The wall in the rear of the washers in the laundry room and hallway walls outside of the laundry observed
	residents' bathrooms were debris.			damaged and soiled will be repaired, cleaned and completed by 11/12/06.
La.	Garden Level rooms 169, 182, 186; 192, 194, 195 and observations between 11:3 approximately 1:00 PM on (	d 197 in 11 of 14 0 AM and		• The armrest, backs and leg surfaces of dinning room chairs identified as worn
	Beauty Shop in two (2) of fo 10:30 AM on October 6, 20	06.		marred and scarred will be repaired or replaced by 11/19/06.
	Lower Level rooms 087 and (9) observations between 2 on October 5, 2006.			• The bathroom doors identified as damaged, marred, scarred and
	3. The Sonozaire deodorize garage near the trash dump outer surfaces in one (1) of approximately 4:15 PM on (	oster was soiled on the one (1) observation at		splintered will be repaired and completed by 11/19/2006.
	4. Paper and soiled product the floor and surrounding at dumpster in the garage in o observations at 4:20 PM on	reas of the trash ine (1) of one (1)		2. Environmental Rounds were conducted 10/25/06 and no other deficiencies were noted.
	<ol> <li>5. Floor surfaces and surro small laundry room were so</li> <li>1) observation at 4:25 PM of</li> </ol>	iled in one (1) of one ( on October 4, 2006.		3. The Maintenance Supervisor or designee will conduct monthly preventive maintenance rounds. All work
	6. Plastic vertical slats loca the laundry area were soiled ) of one (1) observation at 4 9760 00) Provide Norshea Plantek	d and stained in one (1		generated will be completed within 48 – 72 hours with written affirmation.

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	2006 17:25 2023630950 SERVICES	IN	GLES	FORM	E 04/09 10/13/2006 APPROVED 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	(X2) M A BUI		LE CONSTRUCTION	
	095028	S WI			6/2006
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	012000
INGLESI	DE PRESBYTERIAN RETIREM			50 MILITARY ROAD NW ASHINGTON, DC 20015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3	F	253	4. The Facility Management	
	2006.			Director will conduct random audits and will be presented	
	7. Wall surfaces in the rear of washers in the laundry room and hallway walls outside of the laundry were damaged and soiled in two (2) of two (2) observations at 4:28 PM on October 4, 2006.			monthly to the QA committee.	
	8. The armrest, backs and leg surfaces of dining room chairs were worn, marred and scarred in the lower level dining room in seven (7) of nine (9 ) observations at approximately 2:45 PM on October 6, 2006.	•			
	9. The frontal surfaces of entrance and bathrooms doors were damaged, marred, scarred and splintered on the edges in rooms 070, 072, 085, 094 and 099 in five (5) of 14 observations between 2:25 PM and 3:45 PM on October 5, 2006.				
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F	276	Corrective Action for Affected <u>Residents:</u> 1. Resident #8 has a completed quarterly MDS on the chart. 10/10/06	
	This REQUIREMENT 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 facility staff failed to complete a quarterly Minimum Data Set (MDS) for Resident #8.				
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		HAND HUMAN SERVICES				FORM	10/13/2006 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDIN	*	(3) DATE SI COMPLE	
		095028	B. WI	NG _		10/0	6/2006
	ROVIDER OR SUPPLIER	RETIREM		3	EET ADDRESS, CITY, STATE, ZIP CODE 050 MILITARY ROAD NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEF	CROSS-	(X5) COMPLETION DATE
F 276	Continued From pa The findings includ	-	F	276	Procedure for Identifying Potentially Affected Residen		01/10/2007
	quarterly MDS asso 2006. There was r	nt # <u>8</u> 's record revealed a essment completed April 14, no evidence that a quarterly or ent was completed after April			<ul> <li>2. All records will be audit insure quarterly and annua reviews are present. 10/10/ <u>Measures Adopted for System</u> Change:</li> </ul>	1 /06	
	Director of Nursing AM. He/she ackno	view was conducted with the on October 5, 2006 at 10:00 wledged that the quarterly was not completed. The ed October 5, 2006.		••	3. All Unit Managers will educated on the MDS proc All Unit Managers will be educated on the electronic	ess.	
	· ·	Y			process for MDS complian The MDS coordinator will monitor MDS compliance weekly starting 11/01/06. ( going.		
					Monitoring of Corrective Ac and Quality Assurance:		
					4. The MDS coordinator w report monthly on the MDS compliance over the next 9 days. Starting 10/10/2006. 01/10/2007	S	
	567(02-99) Previous Versions	Obsolete Event ID: QK21 1	1 1-1	icility I	9. PRESIVITIN II Configur	ation shee	Page 5 of 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM       B. WING       10/06/2006         INGLESIDE PRESBYTERIAN RETIREM       STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015       10/06/2006         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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)       (X3) COMPLETION DATE         F 278       483.20(g) - (j) RESIDENT ASSESSMENT       F 278       F 278         The assessment must accurately reflect the resident's status.       F 278       F 278         A registered nurse must conduct or coordinate       Corrective Action for Affected Residents:			AND HUMAN SERVICES				FORM /	10/13/2006 APPROVED 0938-0391
MARE OF PROVIDER OR SUPPLIER     10/06/2005       INGLESIDE PRESBYTERIAN RETIREM     SHEET ADDRESS, CITY STATE, 2P CODE Se6 MULTARY ROAD NW WASHINGTON, DC 20015       (M1)D PREEX TAC     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL RECUR CORRECTIVE ACTION SINULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY     D PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT     D PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SINULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY     D COMPLETION (EACH CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT     D PROVIDER OF CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT     D PROVIDER OF CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT     D PROVIDER OF CORRECTIVE ACTION FOR ALL CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT     D PROVIDER ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT SINULD BE CORRECTIVE ACTION SINULD BE CROSS- BULL RESIDENT ASSESSMENT IS SUBJECT 0 CAVID ROPE SIDENT ASSESSMENT IS SUBJECT 0 CAVID ROPE SIDENT OF CORPLEXA SUBJECT 0 CAVID ROPE SIDENT OF CORPLEXA SUBJECT 0 CAVID ROPE SIDENT OF CORPLEXA SUBJECT 0 CAVID ROPE SIDENT OF OTO THE APPROPRIATE DEFICIENCY WaSCINCE TO SUBJECT OF SIDENT ASSESSMENT IS SUBJECT 0 CAVID ROPE SIDENT OF CORPLEXA SUBJECT 0 CAVID ROPE SIDENT ASSESSMENT IS SUBJECT 0 CAVID ROPE SIDENT ASSESSMENT IS	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			¢		
INGLESIDE PRESBYTERIAN RETIREM       3958 MILITARY ROAD NW WASHINGTON, DC 20015         PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCENCY MUST BE PRECEEDED BY FULL REQUERCED TO THE APROPRIATE DEFICIENCY TAG       PROVIDENT ASSESSMENT         F 278       483 20(g) - () RESIDENT ASSESSMENT       F 278         SS=D       The assessment must accurately reflect the resident's status.       F 278         A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.       F 278         A registered nurse must sign and certify that the assessment must sign and certify the accuracy of that portion of the assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is a material and false statement in a resident assessment is a subject to a civil money penalty of not more than \$1,000 for each assessment is on ther individual to certify a material and false statement.       Nonitoring Corrective Action and Quality Assurance: 4. The MDS coordinator will audit the Medical Records for a 90-day perially of not more than \$1,000 for each assessment is a subject to a civil money penalty of not more than \$1,000 for each assessment is a brief to a civil money penalty of not more than \$5,000 for each assessment.       Monitoring Corrective Action and Quality Assurance: 4. The MDS coordinator will audit the Medical Records for a 90-day period November, December and January and report findings the QA committee monthly. 01/30/07         Based on record review and staff interview for on (1) of 15 sampled residents; it was determined that the facility staff faled to sign the Minimum Data Set (MDS) assessment to ong (EI) of RESAMENT is not met as evidenced by c			095028	B. WI	NG		10/06	5/2006
PHEFX TAG       PLEFX TAG       PLEFX TAG       COMPLETION REFERENCE DTO THE APPROPRIATE DEFICIENCY       COMPLETION DATE         F 278 SS=D       483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.       F 278       F 278         A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.       F 278       F 278         A registered nurse must sign and certify that the assessment is completed.       F 278       Corrective Action for Affected Resident's: 1. Resident #15, R2a was signed as of 10/06/2006       11/19/06         Under Medicare and Medicaid, an individual who wilfully and knowingly certifies a material and faise statement in a resident assessment subject to a civil money penalty of not more than \$1,000 for each assessment.       S. All Unit Managers will be educated on the MDS process.         Of indical disagreement does not constitute a material and faise statement.       This REQUIREMENT 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 facility staff failed to sign the Minimum Data St (MDS) assessment to indicate completion at R2a (Signature of RN Assessment Coordinator). Resident #15.			RETIREM		30	50 MILITARY ROAD NW		
<ul> <li>SS=D The assessment must accurately reflect the resident's status.</li> <li>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</li> <li>A registered nurse must sign and certify that the assessment is subject to a civil money penalty of not more than \$1,000 for each assessment.</li> <li>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment.</li> <li>Clinical disagreement does not constitute a material and false statement.</li> <li>This REQUIREMENT is not met as evidenced by</li> <li>Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility staff failed to sign the Minimum Data Set (MDS) assessment to indicate completion at R2a (Signature of RN Assessment</li> </ul>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE	CROSS-	COMPLETION
Minimum Data Set (MDS) assessment to indicate completion at R2a (Signature of RN Assessment Coordinator). Resident #15.		The assessment m resident's status. A registered nurse each assessment w participation of hea A registered nurse assessment is com Each individual wh assessment is com Each individual wh assessment must s that portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each as willfully and knowin to certify a material resident assessme penalty of not more assessment. Clinical disagreeme material and false s This REQUIREME : Based on record re one (1) of 15 samp	<ul> <li>aust accurately reflect the</li> <li>must conduct or coordinate with the appropriate lith professionals.</li> <li>must sign and certify that the pleted.</li> <li>b completes a portion of the sign and certify the accuracy of assessment.</li> <li>d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each</li> <li>ent does not constitute a statement.</li> <li>NT is not met as evidenced by wiew and staff interview for led residents, it was</li> </ul>	F	278	<ul> <li>Corrective Action for Affect Residents:</li> <li>1. Resident #15, R2a was sign of 10/06/2006</li> <li>Procedures for Identifying Potentially Affected Resider</li> <li>2. An audit of all Medical Rec was conducted to insure that a R26 dates were appropriately signed. 10/31/2006</li> <li>Measures Adopted for Syste Change:</li> <li>3. All Unit Managers will be educated on the MDS process 11/19/2006</li> <li>Monitoring Corrective Act and Quality Assurance:</li> <li>4. The MDS coordinator will the Medical Records for a 90 period November, December January and report findings the</li> </ul>	ned as nts: cord all emic s. ion 1 audit D-day and he QA	11/19/06
		completion at R2a Coordinator). Resi	(Signature of RN Assessment dent #15.					

	MENT OF HEALTH AND HUMAN SERVICES				PRINTED: 10/13/2000 FORM APPROVED OMB NO: 0938-039	
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION UMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		4	(X3) DATE SURVEY COMPLETED	
	095028	B. WI	NG		10/06	5/2006
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
INGLESH	DE PRESBYTERIAN RETIREM		1	ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 278	Continued From page 6	F	278			
	The findings include:					
	A review of Resident #15's closed record revealed an admission MDS completed August 1, 2006. Section R2a, "Signature of RN Assessment Coordinator", was blank.					
	A face-to-face interview was conducted with the Director of Nursing on October 6, 2006 at 2:30 PM. He/she acknowledged that Section R2a was not signed. The record was reviewed October 5, 2006.					
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			and some and			
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1-125 7.455 24	67(67-59) Pressions Viewians Ons doler		eildise M	D. PRESSYTERV H countin	watern smoot	Page 7 of 23

		H AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	G	(X3) DATE SU COMPLE	
		095028	B. WING		10/0	6/2006
	PROVIDER OR SUPPLIER	RETIREM	3	REET ADDRESS, CITY, STATE, ZIP CODE 050 MILITARY ROAD NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS-	(X5) COMPLETIO DATE
F 279 SS=D	CARE PLANS A facility must use to develop, review comprehensive pla The facility must d plan for each resid objectives and tim medical, nursing, a needs that are ide assessment. The care plan must to be furnished to highest practicable psychosocial well- 25; and any servic required under §4 to the resident's ex- including the right	(k)(1) COMPREHENSIVE the results of the assessment and revise the resident's an of care. evelop a comprehensive care lent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive st describe the services that are attain or maintain the resident's e physical, mental, and being as required under §483. es that would otherwise be 83.25 but are not provided due kercise of rights under §483. 10, to refuse treatment under §483.	F 279	Corrective Action for Aff Residents: 1. Resident # 6 was given a anticoagulant care plan.10/ Procedures for Identifyin Potentially Affected Resid 2. All residents on anticoag will be reviewed to insure to anticoagulant care plan is in 10/30/06 Measures Adopted for Sy Change: 3. All nursing staff will be service on the importants an anti coagulant care plan	n 06/06 g lents: ulants hat an n place. stemic e in- of adding	11/19/06
	: Based on observa review for two (2) determined that fa care plan with app for one (1) residen one (1) resident fo intravenous] ABT therapy and a left The findings include 1. Facility staff fail	ENT is not met as evidenced by tion, staff interview and record of 15 sampled residents, it was cility staff failed to initiate a ropriate goals and approaches it on anticoagulant therapy and r isolation, infection, IV [ [antibiotic], pain, anticoagulant leg brace. Residents #6 and 11. de: ed to initiate a care plan for apy for Resident #6, admitted to		resident is started on an anticoagulant. Monitoring Corrective A and Quality Assurance: 4. The Unit Managers wi complete a 24 hr. chart an insure that anticoagulant are in place. 11/19/2006 Unit Managers will moni Anticoagulant care plans compliance for 90 days a finding with the QA com monthly.	ll udit to care plans tor nd share	

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING		(X3) DATE SI COMPLE	
		095028	B. WING		10/0	6/2006
	(EACH DEFICIENCY	RETIREM TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)		TREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ECTION LD BE CROSS-	(X5) COMPLETION DATE
F 279	physician's order d renewed May 1, Ju 16, 2006, "Lovenox daily for DVT (Deep The care plan, initia reviewed July 25, 2 plan with appropria the use of Lovenox A face-to-face inter Coordinator was co 9:30 AM. He/she a care plan for antico was reviewed Octo 2. Facility staff faile Resident #11 for is anticoagulant thera A review of Reside the resident was ac September 26, 200 Periprosthetic infeo left distal and femo clostridium difficile. According to the ph September 26, 200 Metronidazole for o via IV for Periprost and Dilaudid for pa	2006. nt #6's record revealed a ated April 19, 2006, and ne 26, July 29 and September c 0.4 mg sq (subcutaneously) o Vein Thrombosis)." ated April 24, 2006 and 006, failed to include a care te goals and approaches for , an anticoagulant drug. view with the Resident Care enducted on October 5, 2006 at icknowledged the lack of a agulant therapy. The record	F 27	<ul> <li>9 F279</li></ul>	ns have ing sidents: Records lan Systemic laily 24hr. or care plan Action l dit to are plans or care sys and	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		095028	B. WING	·	10/0	6/2006	
	ROVIDER OR SUPPLIER	RETIREM		REET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE	
F 279	Further review of th evidence that a car the resident's care IV ABT, pain, antice brace. A face-to-face inter Supervisor was cor	age 9 ne clinical record lacked re plan was initiated to address needs for isolation, infection, oagulant therapy and a left leg view with the Evening nducted on October 4, 2006 at acknowledged that the record	F 279				
F 280 SS=D	lacked care plans f pain, anticoagulant The record was rev 483.20(d)(3), 483.1	or isolation, infection, IV ABT, therapy and a left leg brace. viewed October 4, 2006.	F 280	<sup>)</sup> F 280			
	incompetent or oth incapacitated unde participate in plann changes in care an A comprehensive of within 7 days after comprehensive ass interdisciplinary tea physician, a register	r the laws of the State, to ing care and treatment or d treatment. care plan must be developed the completion of the sessment; prepared by an im, that includes the attending ered nurse with responsibility	·	Corrective Action for Affe Residents: 1. Resident #13 Falls care p been brought up to date. 10 Procedures for Identifyin Potentially Affected Resi 2. All residents that have for the last 90 days will be rev for care plan updates. 10/3	olan has /06/06. g dents: allenin iewed	11/19/06	
	for the resident, an disciplines as deter and, to the extent p the resident, the re legal representative and revised by a te each assessment.	d other appropriate staff in mined by the resident's needs, practicable, the participation of sident's family or the resident's a; and periodically reviewed am of qualified persons after			0/08		

		AND HUMAN SERVICES			FORM	10/13/2006 APPROVED 0938-0391
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F 280	Based on observat review for one (1) of determined that fac plan for one (1) res Residents #13. The findings includ The review of the in Resident #13 inclu Prevention" dating recent falls with no 7/5/06, 7/24/06, an to "Continue with a care plan was not of interventions. On October 5, 2000 face-to-face intervi- nurse manager who	ion, staff interview and record of 15 sampled residents, it was cility failed to update a fall care ident with multiple falls. e: nterdisciplinary care plan for ided a problem for "Fall from April 13, 2004. The injuries were 1/3/06, 4/10/06, d 10/3/06. It was documented pproaches" after each fall. The updated to include new 6 at approximately 11:00 AM a ew was conducted with the o acknowledged that new not implemented. The record	F 2	<ul> <li>Measures Adopted for Change:         <ol> <li>For residents that fall, review and updates will place@ daily morning m part of the fall preventio</li> <li>Licensed staff will be in on the falls prevention p care plans updates. By</li> </ol> </li> <li>Monitoring Corrective and Quality Assurance 4. Unit Managers will re care plan updates at the meeting monthly. 11/06</li> </ul>	care plan be taking neeting as n process. -serviced rocess and 11/30/06 Action e: port falls QA	
F 323 SS=D	The facility must er environment remai as is possible. This REQUIREMEI : Based on observat it was determined t that the environment hazards as evidence	DENTS issure that the resident ins as free of accident hazards NT is not met as evidenced by ions during the survey period, hat facility staff failed to ensure int was free from accidental sed by: excessive electrical d to extension cords, a candle	F 3:			
DRIACMIS-3	Ori 02-99) Previous Vensus	s based at the second sec	l ligo	aliyes exestitory I con	invertion sheet	Page A of 28

It continuation sheet have it of 28

	IPLE CONSTRUCTION	NULTIP	1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	NT OF DEFICIENCIES OF CORRECTION	
/06/2006	10/0	NG	8. W	095028		
	REET ADDRESS, CITY, STATE, ZIP CODE 050 MILITARY ROAD NW VASHINGTON, DC 20015	30			PROVIDER OR SUPPLIER	NGLESI
	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	IX	ID PREI TAI	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENCY	(X4) ID PREFIX TAG
;	<ul> <li>F323 Accidents</li> <li>1. The multiple electrical appliances connected to a multiplug that was attached to an extension cord and other electrical devices identified or observed were disconnected and removed on 10/04/2006.</li> <li>Candle observed burning was removed in a residents room was removed in a residents room was removed immediately on 10/04/06.</li> <li>All Oxygen tanks identified were secured and completed 10/06/06.</li> <li>The floor drain cover observed unsecured in the apartments kitchen was repaired 10/25/06.</li> <li>All rooms and resident areas were check for candles, unsecured floor drains related to these observations.</li> </ul>	323		at's room and unsecured floor drain. These made in the presence of the mance and Houşekeeping and e: appliances were observed on cords in a resident's room. ar, an observation of room 70 ber 4, 2006 at 2:30 PM. A r, fan and microwave oven multi-plug which was attached d. Additionally, a DVD and attached to an extension cord e top of the Heating litioning unit, behind the bed e cords were held together	<ul> <li>oxygen tanks and a observations were in Directors of Mainten nursing staff.</li> <li>The findings included</li> <li>Multiple electrica attached to extension</li> <li>During the initial too was made on Octoor blender; refrigerato were attached to a to an extension correctelevision unit was in which ran across the Ventilation Air Concernant into a plug. The with metal twist ties</li> <li>A candle was observation.</li> <li>A face-to-face intermined to the plane into a plane.</li> </ul>	F 323
		ander one and a set of the set of		ated, "My [family member] urns them when [he/she] visits lows the candle out when [he/ esident was asked if he/she nd replied, "No, I don't light ave any matches. My [family	likes candles and b . Usually [he/she] b she] leaves." The r had any matches, a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDIN		
	·····	095028	B, Wil	NG	10/	06/2006
	ROVIDER OR SUPPLIER	RETIREM		3	REET ADDRESS, CITY, STATE, ZIP CODE 1050 MILITARY ROAD NW WASHINGTON, DC 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) CCMPLETION DATE
F 323	member] lights the A face-to-face inter charge nurse on O /she acknowledged that the family men with his/her relative 3. Oxygen tanks we both resident units. Garden Level: Two observed unsecure on October 4, 2006 Lower Level: Two ( were observed uns 11:30 AM.	candle." view was conducted with the ctober 4, 2006 at 2:40 PM. He I that facility staff was aware observed unsecured on (2) oxygen tanks were d in two (2) of 2 observations at 3:45 PM. 2) of five (5) oxygen tanks ecured on October 5, 2006 at	F (	323	<ul> <li>3. The environmental Services Director or designee will add Items identified or observed during this survey to the environmental rounds schedule weekly. This compliance will continue weekly times 4 and random monthly thereafter. 11/01/06</li> <li>4. Results of this audit will be presented to the QA committee</li> </ul>	11/19/06
F 371 SS=E	apartment kitchen. On October 4, 2006 cover located in the observed unsecure across.	er was unsecured in the 5 at 2:00 PM, a floor drain apartment kitchen was d and moved when walked ARY CONDITIONS - FOOD	F	371	monthly times three. Nov., Dec. & Jan. 2007 F 371	
	serve food under sa This REQUIREMEN	ore, prepare, distribute, and anitary conditions. NT is not met as evidenced by			<ul> <li>Corrective Action for Affected Residents: <ol> <li>No residents were affected.</li> <li>Walls, ceiling tile surfaces and air supply vents observed to be soiled were</li> </ol> </li> </ul>	

DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES					10/13/2006 APPROVED
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F 371	Based on observat it, was determined adequate to ensure served in a safe an evidenced by: soile vents over cooking covers in the walk- the water supply lin clean and soiled sim mechanical can op bottom surfaces of surfaces of juice gl hood filters, the du suites kitchen and stored in the walk- i expiration date. The the presence of the The findings includ 1. Walls, ceiling till were soiled with ac areas in the apartment 1) observation at 3. 2. Compressor fam accumulated dust a apartment refrigera observations at 3:4 3. The prefilter on the cooking hoods was accumulated miner in the apartment king	ions during the survey period that dietary services were not a that foods were prepared and do sanitary manner as ad walls, ceiling tiles, air supply areas, compressor fans and in refrigerator, the pre-filter of he, dishwasher slats on the de, cutting surfaces of the ener and holder, top and plates, hotel pans, the bottom asses, the broiler grill, cooking mpster area outside of the cartons of buttermilk were n refrigerator beyond the hese findings were observed in a dietary managers.		371	<ul> <li>10/10/06.</li> <li>Compressor fans and cover identified to be soiled in the apartments walk-in refrigerator was cleaned and completed on 10/06/00.</li> <li>The pre filter identified on the water supply line near the cooking hoods was cleaned and completed 10/06/06.</li> <li>The pastic slates identifie on the clean and soiled side of the dish washer in the apartments was cleaned a completed on 10/10/06.</li> <li>The cutting and holder of the mechanical can opene identified in the apartment kitchen was cleaned and completed on 10/06/06</li> <li>The hotel pans observed were cleaned and comple on 10/05/06. In-serviced utility staff 10-22-06, concerning air-drying of equipment and the correct way that dishware should placed in the dish machin Also reviewed the correct</li> </ul>	ers 06. n d de nd er nt ted the ted the t ted the t	
		he clean and soiled side of the apartment kitchen were soiled			temperature of the wash rinse cycle of the machin		
U.R.N. Calis-2	537(02-99) Paganas Versions	Obsoide Event#FGE44	Fa	arilian	(R) PRESSYLLAS: # COME	eatiliain sheed	Page 14 of 22

		AND HUMAN SERVICES				FORM	10/13/2006 APPROVED 0938-0391
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F 371	<ul> <li>products in one (1)</li> <li>PM on October 4, 2</li> <li>5. The cutting and mechanical can op were soiled with left</li> <li>) of one (1) observed 2006.</li> <li>6. The top and both soiled with leftover before they were a observations at 8:4</li> <li>7. The interior and (12 x 24 x 6 inch) vafter washing in the pans were not allow racks for reuse in a observations at 9:3</li> <li>8. The bottom surfaces for reuse in a observation of the soiled and stained washing in eight (8 approximately 10:0</li> <li>9. The broiler grill gaccumulated food cook's area of the one (1) observation 2006.</li> <li>10. The interior and with grill with grill of the soiled with g</li></ul>	nineral deposits and other of one (1) observation at 3:15 20006. holder surfaces of the ener in the apartment kitchen ftover food and debris in one (1 ation at 3:20 PM on October 4, com surfaces of plates were foods and plates were stored llowed to dry in eight (8) of 28 15 AM on October 5, 2006. exterior surfaces of hotel pans vere soiled with leftover food e pot and pan wash area and wed to dry before storing on	F	371	<ul> <li>The bottom surfaces of juice glass observed we cleaned and completed 10/06/06. Water softer vessel was serviced dut the inspection and will placed on a PM schedu Glassware with mineral deposits will be washe eliminate this debris.</li> <li>The broiler grill grates observed in the apartm kitchen was cleaned and completed on 10/06/06.</li> <li>The interior areas of th cooking hood filters observerd soiled was cleaned and completed 10/06/06.</li> <li>The paper and soiled products observed on the floor and surrounding a of the dumpster near th suites kitchen were cleaned and completed on 10/06/2006</li> <li>Cartons of Butermilk observed in the walk in refrigerator that were expired were destroyed 10/05/06.</li> <li>The Dining Service Direct or designee in each of the</li> </ul>	ere her ring be ile. il d to ents id e on he ureas e aned	
BREAK MEL 24	Vid(02-99) Pasvinas Versios	; Obské – Vyn: k): ORZ(11		div ft	PRESENTER D confis	a dian sheet	Pargie - 15-04-22

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F 371	<ol> <li>Paper and soile the ground outside suites kitchen in or 2:25 PM on Octobe</li> <li>Cartons of but refrigerator were st date. The date of e</li> </ol>	ed products were observed on of the dumpster near the e (1) of one (1) observation at	F 3	<ul> <li>Ingleside kitchens will cona sanitation audit monthly Service Manager or desig will conduct weekly audit</li> <li>3 .The Dining Service Dinwill monitor daily and corrective action will be t to maintain compliance w standards as needed based the results of the audits.</li> </ul>	r. The nee rector aken vith	11/19/06
F 385 SS=D	A physician must p recommendation th a facility. Each resister of a physician The facility must er each resident is su another physician s residents when the unavailable. This REQUIREMENT Based on observat review for three (3) was determined that complete the annual assessment for Re The findings includ	ersonally approve in writing a nat an individual be admitted to sident must remain under the asure that the medical care of pervised by a physician; and supervises the medical care of ir attending physician is NT is not met as evidenced by ion, staff interview and record of 15 sampled residents, it at the physician failed to al history and physical sidents #1, 4, and 9.	F 3	<ul> <li>4.Sanitation audits and net action plans will be report the QA committee meetin monthly. 11/06</li> <li>F 385</li> <li>Corrective Action for A Residents: <ol> <li>Residents:</li> <li>Residents #1, 4 and 9 I completed H &amp; P on the 10/31/06</li> </ol> </li> <li>Procedure for Identifyin Potentially Affected Residents: <ol> <li>Medical records audits completed to ensure the I done. The MD will be concomplete any delinquent found. 10/30/06</li> </ol> </li> </ul>	ffected <u>ffected</u> haves a chart. <u>ng</u> <u>sidents:</u> will be H&P are intacted to	

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TAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGREFERENCED TO THE APPROPRIATE DEFICIENCY)DATEF 385Continued From page 16 under "Procedure - 1. All residents must have an annual history and physical by their attending physician after being in the facility (1) year."F 385Measures Adopted for Systemic Change: 3. MD 's will be educated on the facilities policy and procedures regarding H&P's and their completion.1. The attending physical affer being in the facility (1) year."F 385Measures Adopted for Systemic Change: 3. MD 's will be educated on the facilities policy and procedures regarding H&P's and their completion.A review of Resident #1's record revealed that the most current History and Physical assessment was signed and dated September 25, 2005 by the attending physician.F 385Measures Adopted for Systemic Change: 3. MD 's will be educated on the facilities policy and procedures regarding H&P's and their completion.A face-to-face interview was conducted with medical records staff on October 6, 2006 at 9:30 AM. He/she stated, "I keep a list of when all the history and physical form in the record about a month before it's due and flag it for the physician." The record lacked evidence of a blank history and physical form for the physician to complete. The record was reviewed on October 6, 2006.• The Medical Director will be required to complete the H&P's is at2. A review of the clinical record for Resident #4 revealed that the physical failed to complete an annual history and physical (H&P) examination.Monitoring of Corrective Action and Quality Assurance: 4. The Medical Records Coordinator will audit records and report compliance of H&P's at<			AND HUMAN SERVICES				FORM	10/13/2006 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     10/06/2006       INOLESIDE PRESENTERIAN RETIREM     STREET ADDRESS. CITY. STATE. 2P CODE 3950 MILITARY ROAD NW WASHINGTON, DC 20015       INOLESIDE PRESENTERIAN RETIREM     STREET ADDRESS. CITY. STATE. 2P CODE 3950 MILITARY ROAD NW WASHINGTON, DC 20015       F 385     Continued From page 16 under "Proceedure - 1. All residents must have an annual history and physical fuel the facility (1) year."       1. The attending physical failed to complete an annual history and physical assessment was signed and dated September 25, 2005 by the attending physicals and dated September 25, 2005 by the attending physical form in the record about a month before its due and flag it for the physican." The record tacket dividence of the complete an annual history and physical form in the record about a month before its due and flag it for the physican." The last H&P was dated August 31, 2005. A face -to-face interview was conducted with the record was reviewed on October 6, 2006.       2. A review of the clinical record for Resident #4 revealed that the physical field to complete an annual history and physical state out to complete. The last H&P was dated August 31, 2005. A face -to-face interview was conducted with the nurse manager who acknowledged that the H&P was delinquent. The record was reviewed on October 5, 2006.     The physican failed to complete the annual history and physical state with the H&P was delinquent. The record was reviewed on October 5, 2006.     The physican failed to complete the annual history and physical state was reviewed on October 5, 2006.     The physican failed to complete the annual history and physical assessment for Resident #9.			IDENTIFICATION NUMBER:	l' í		¢		
INCLESIDE PRESBYTERIAN RETIREM       395 MILITARY ROAD NW         MILITARY ROAD NW       WASHINGTON, DC 20015         PREFIX       SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSCIDENTIFYING NFORMATION)       PREFIX       PREFIX       REFERENCED TO THE APROPRIATE DEFICIENCY       ComPLETO (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH DEPICENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSCIDENTIFYING NFORMATION)       PREFIX       REFERENCED TO THE APROPRIATE DEFICIENCY       ComPLETO (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH DEPICENCY)       ComPLETO (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH DEPICENCY)       ComPLETO (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH DEPICENCY)       ComPLETO (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH CORRECTIVE ACTION SHOULD BE CROSS. (ACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH CORRECTIVE ACTION SHOULD BE CROSS. (EACH CORRECTIVE ACTION SHOULD BE CROSS. (ACH CORRECTIVE ACTION SHOULD BE CROSS. (ACH CORRECTIVE ACTION SHOULD BE CROSS. (ACH CORRECTIVE ACTION SHOULD B			095028	B. WI	NG_		10/0	6/2006
<ul> <li>PREFIX TAG</li> <li>PREFX TAG</li> <li>PREFX</li> <li>(EACH CORRECTIVE ACTION SHOLD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY TAG</li> <li>PREFX</li> <li>Continued From page 16 under "Procedure - 1. All residents must have an annual history and physical by their attending physician failed to complete an annual history and physical assessment for Resident #1.</li> <li>A review of Resident #1's redord revealed that the most current History and Physical assessment was signed and dated September 25, 2005 by the attending physical form in the record boott a month before its due and flag it for the physican to complete. The record lacked evidence of a blank history and physical form in the record boott a annual history and physical to complete an annual history and physical assessment for Resident #1.</li> <li>A review of Resident #1's redord revealed that the most current History and Physical assessment was signed and fated September 25, 2005 by the attending physical form in the record boott a month before its due and flag it for the physican. The record lacked evidence of a blank history and unal history and physical form in the record boott a annual history and physical form in the record boott a annual history and physical form in the record boott a annual history and physical form in the record boott a annual history and physical form in the record boott a annual history and physical form cheller. The record was reviewed on October 6, 2006.</li> <li>2. A review of the clinical record for Resident #4 revealed that the physican failed to complete an annual history and physical form in the Physican failed to complete an annual history and physical form cheller. The record was reviewed on October 6, 2006.</li> <li>3. The physican failed to complete the annual history and physical form cheller expression failed to complete the annual history and physical form cheller expression failed to complete the specific physical form cheller expression failed to complete the for 2006.</li> <li>3. The physican</li></ul>	INGLESI	DE PRESBYTERIAN			3	3050 MILITARY ROAD NW WASHINGTON, DC 20015		
<ul> <li>Change:</li> <li>3. MD 's will be educated on the facilities policy and procedures regarding H&amp;P's and their completion.</li> <li>a review of Resident #1's record revealed that the most current History and Physical assessment was signed and dated September 25, 2005 by the attending physicals are due. I place a blank history and physical form in the record about a month before it's due and flag it for the physician.</li> <li>A review of the clinical record for Resident #4 revealed that the physical form for the physical to complete. The record lacked evidence of a blank history and physical form for the physical to complete. The record acked evidence of a blank history and physical form for the physican to complete. The record the physican failed to complete an annual history and physical (H&amp;P) examination.</li> <li>The last H&amp;P was dated August 31, 2005. A face to-face interview was conducted with the nurse manager who acknowledged that the H&amp;P was delinquent. The record was reviewed on October 5, 2006.</li> <li>The physician failed to complete the annual history and physical assessment for Resident #9.</li> </ul>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETION
most current history and physical assessment in C. 44 CEES 2667(52-59) Previous Versions Outpole/u Event ID: OK2C11 Lacility ID: PRESBYTER// If continuation sheet Page 17 of	F 385	under "Procedure - annual history and physician after bein 1. The attending ph annual history and Resident #1. A review of Reside most current Histo was signed and da attending physician A face-to-face inter medical records sta AM. He/she stated history and physica history and physica month before it's du The record lacked physical form for the record was reviewed 2. A review of the co revealed that the pi annual history and The last H&P was of -to-face interview w manager who ackin delinquent. The reco 5, 2006. 3. The physician fa history and physical A review of Reside	<ul> <li>1. All residents must have an physical by their attending ing in the facility (1) year."</li> <li>hysician failed to complete an physical assessment for</li> <li>nt #1's record revealed that the ry and Physical assessment ted September 25, 2005 by the filter of the physical assessment the sequence of a list of when all the sequence of a blank history and flag it for the physician."</li> <li>evidence of a blank history and the physical record for Resident #4 hysician failed to complete an physical (H&amp;P) examination.</li> <li>clated August 31, 2005. A face vas conducted with the nurse hysical the the H&amp;P was cord was reviewed on October iled to complete the annual all assessment for Resident #9.</li> <li>nt #9's record revealed that the y and physical assessment in</li> </ul>		385	<ul> <li><u>Change:</u></li> <li>3. MD 's will be educated facilities policy and proce regarding H&amp;P's and their completion.</li> <li>If MD is not complet H&amp;P in a timely mhe/she will be conthe Medical Direct Administrator.</li> <li>The Medical Director required to complet H&amp;P if the attending Physician is not a 11/06</li> <li><u>Monitoring of Corrective and Quality Assurance:</u></li> <li>4. The Medical Records Coordinator will audit records Coordinator will audit records Coordinator will audit records 11/06</li> </ul>	on the dures r ing the hanner, tacted by tor or r will be ete the ing vailable. <b>e Action</b> ords and "s at eetings.	11/19/06

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE CROSS-	(X5) COMPLETI DATE
F 385	the record was da A face-to-face inte Resident Care Co 3:45 PM. He/she and physical asse	ted September 8, 2005. erview was conducted with the ordinator on October 6, 2006 at acknowledged that the history ssment should have been ober 2006. The record was	F3	385	^	
F 386 SS=D	program of care, in treatments, at eac of this section; wri notes at each visit with the exception polysaccharide va administered per p policy after an ass This REQUIREME : Based on observa interview for two (2 was determined th telephone orders a #5 and J1. The findings includ According to the fa Orders" with an ef number, under "Pr	st review the resident's total including medications and h visit required by paragraph (c) te, sign, and date progress ; and sign and date all orders of influenza and pneumococcal ccines, which may be ohysician-approved facility essment for contraindications. ENT is not met as evidenced by tion, record review and staff 2) of 15 sampled residents, it tat the physician failed to sign as per facility policy. Residents	F 3	<ul> <li>F386</li> <li><u>Corrective Action</u> <u>Residents:</u> <ol> <li>Residents #5 and orders have been si</li> <li><u>Procedure for Iden</u> <u>Potentially Affector</u></li> <li>All current reside be audited for MD MD's will be conta orders.</li> </ol> </li> </ul>	J1 telephone gned. 11/01/06 ntifying ed Residents: ents records will signatures.	

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		AND HUMAN SERVICES				FORM	10/13/2006 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		095028	B. WI	NG		10/0	6/2006
	ROVIDER OR SUPPLIER DE PRESBYTERIAN	RETIREM		3	REET ADDRESS, CITY, STATE, ZIP CODE 0050 MILITARY ROAD NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 386	<ol> <li>The physician fa for Resident #5 as</li> <li>A review of Reside physician failed to so orders: July 25, 29, (2 orders), 7, 9, 10, orders) and Septer</li> <li>Physician progress record and dated J 20 and 31, 2006 ar</li> <li>A face-to-face inter Resident Care Coo 2006 at 7:00 AM. If physician had not st telephone orders. October 5, 2006.</li> <li>The physician fa for Resident J1 as</li> <li>A review of Reside physician failed to telephone orders:</li></ol>	iled to sign telephone orders per facility policy. Int #5's record revealed that the sign the following 19 telephone 30 and 31, 2006, August 1, 6 , 11, 16, 17 (2 orders), 24 (2 nber 21, 22 and 25, 2006. Inotes were present in the uly 25, 2006, August 4, 7, 19, nd September 13 and 28, 2006. View was conducted with the ordinator (RCC) on October 5, He/she acknowledged that the signed the above cited The record was reviewed iled to sign telephone orders per facility policy. Int J1's record revealed the sign the following five (5) June 10 and 12, 2006, August and September 10, 2006. View was conducted on 11:30 AM with the RCC. He/ that the above cited telephone and by the physician. The	F	386	Measures Adopted for S Change:3. MD 's will be educated facilities policy and proced regarding signing telephon and their completion.MD's not in compliance w signing telephone orders w notified by the Medical Di Administrator.The Medical Director will required to sign telephone the Attending physician is available.Monitoring of Corrective and Quality Assurance: 4. Medical Record will rep for 90 days of MD's signat telephone orders at the QA committee meeting monthl November, December & Ja	on the dures he orders with vill be rector or be orders if not e Action ort rates tures for	11/19/06
ORM CE S 2	567(02-95) Previous Varsion	. Obsoluto i ventuor QR/141		olitj	ID 198 SRY IL RP II Confin	nation sheet	Page 19 of 22

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	JILDING		(X3) DATE SI COMPLE	
		095028	B. WI	ING		10/0	6/2006
INGLES	PROVIDER OR SUPPLIER			305 WA	ET ADDRESS, CITY, STATE, ZIP CODE 50 MILITARY ROAD NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE
F 441 SS=E	The facility must es infection control pro- safe, sanitary, and to prevent the deve- disease and infecti an infection control investigates, contro- the facility; decides isolation should be resident; and main corrective actions r This REQUIREME Based on observat it was determined t were not followed a the Barbicide soluti hair dryers, a brush clean rollers and in oxygen concentrate The findings includ Beauty Shop obser 6, 2006 at 10:30 At 1. Barbicide was cl- in the solution in or 2. The interior surfa with dust in four (4) 3. A hair brush with	stablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of on. The facility must establish program under which it ols, and prevents infections in what procedures, such as applied to an individual tains a record of incidents and elated to infections. NT is not met as evidenced by ions during the survey period, hat infection control practices as evidenced by: particles in on, soiled interior surfaces of a with hair in a container with terior and filter surfaces of a with particles and debris be (1) of one (1) observation. aces of hair dryers were soiled of six (6) observations.	F	441	<ul> <li>F441 Infection Control</li> <li>1. No resident was affected deficiency.</li> <li></li></ul>	by this	

		2023630950	ING	LESIDE AT ROCK CR	PAGE	07/09
11/06/	2006 17:25	2823636365		and star signal		
		H AND HUMAN SERVICES E & MEDICAID SERVICES		LESIDE AT ROCK CR	FORM	10/13/2006 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		095028	B. WIN		10/00	6/2006
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP CODE		
INGLESI	DE PRESBYTERIAN	RETIREM		3050 MILITARY ROAD NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLE?ION DATE
F 441	concentrator in roc 186 were observed debris in two (2) of	age 20 filter surfaces of an oxygen om 170 and the filter in room d with accumulated dust and f 11 observations at 11:30 AM 6 and 12:25 PM on October 6,	F 4	41 3.The Environmental Services Director or designee will add Idems identified or observed during this survey to the environmental		
F 514 SS=D	resident in accorda standards and pra accurately docume systematically orga	naintain clinical records on each ance with accepted professional ctices that are complete; ented; readily accessible; and	F S	14 rounds schedule weekly. This compliance will continue weekly times 4 and random monthly thereafter. 11/01/06		
	information to ider resident's assessn services provided; preadmission scre and progress note	itify the resident; a record of the nents; the plan of care and the results of any ening conducted by the State; s.		4. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec. & Jan. 2007		11/19/06
	: Based on record ro one (1) of 15 samp determined that th document the resid restorative program The findings includ A review of Reside	le: ent #8's record revealed that a "		F 514 <u>Corrective Action for A</u> <u>Residents:</u> 1. Resident #8 will continue functional maintenance prop Flow sheets will be updated	d the gram.	
į	documented, "OT	ted February 20, 2006 [occupational therapy] will write onal maintenance program to				

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CENTERS FOR N TATEMENT OF DEFICIE ND PLAN OF CORRECT	NCIES	K1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) M A. BUI			OMB NO. (X3) DATE SU COMPLE	
		095028	B. WIN	IG		10/0	6/2006
NAME OF PROVIDER OF		RETIREM		305	ET ADDRESS, CITY, STATE, ZIP CODE 50 MILITARY ROAD NŴ ASHINGTON, DC 20015	·	
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [	BE CROSS-	(X5) COMPLETION DATE
increase falls." T An order which wa 2006, dir Ambula increase ambulati A review dated Ju documer functiona 2006. Ti Flow She 2006. A face-to Director PM. He/ participa program until Jun The reco documer functiona 21, 2006	he resider dated Fel as signed I ected, "Fu ate resider bilateral lo on ability." of the "Re ne 2006, r nting the re al maintena here were eets found o-face inter of Nursing she stated ting in the but the sl e 18, 2006 rd lacked nted the re al maintena to June 1	or ambulation to help prevent at had a history of falls. oruary 21, 2006 at 11:00 AM, by the physician on March 7, inctional maintenance program at with walker to all meals to ower extremity strength and	F 5	514	<ul> <li>Procedure for Identifying Potentially Affected Resid</li> <li>2. The Rehab department widentify all residents on a "Functional Maintenance program".</li> <li>The Nurse Managers will in that nursing flow sheets are date.</li> <li>Measures Adopted for System Change:</li> <li>3. The nursing staff will be educated on restorative nur flow sheet documentation.</li> <li>The Charge Nurses will rev restorative flow sheets daily documentation. Restorative sheets will be placed in the books.</li> <li>Monitoring of Corrective and Quality Assurance:</li> <li>4. The unit Managers will restorative documentation compliance for 90 days at the monthly QA committee monthly QA committee monthly QA</li> </ul>	ill asure up to stemic sing 11/19/06 view y for flow ADL <u>Action</u> report the seting.	11/19/06