STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 000	INITIAL COMMENTS The annual recertification survey was conducted on August 31 through September 2, 2010. The following deficiencies are based on observations, staff and resident interviews and record review. The sample size was 15 residents based on a census of 58 on the first day of survey. There were seven (7) supplemental residents.	F 000	**F160** 1. On 8/31/2010 Director of Resident Accounts (DRA) called each Responsible Party for each of the three residents to let them know there was still a balance in the resident's savings account. Informed each Responsible Party that we will be closing the savings account and will be sending them a check for the balance plus closing interest.	08/31/10
F 160 SS=D	483.10(c) (6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview it was determined that facility staff failed to convey within 30 days the residents ' funds upon death for three (3) of three (3) residents with personal funds deposited with the facility. Residents: SM1, SM2 and SM3. The findings include: A review on August 31, 2010 of a report of the Resident Fund Trial Balance dated August 31, 2010 revealed that: Resident SM1 who expired 07/02/10 [July 2, 2010] showed a balance of $164.09; Resident SM2 who expired 02/25/10 [February 25, 2010] showed a balance of $102.21; Resident SM3 who expired 11/27/08 [November 27, 2008] showed a balance of $2,119.92; A face -to-face interview was held on August 31, 2010 at 1:08 PM with Employee #16 who	F 160	On 8/31/2010 DRA processed account status changes in the RFMS banking software to close all three accounts. On 9/1/2010 DRA verified accounts were closed and wrote checks for the closing balance plus interest to each Responsible Party. DRA has monitored the checkbook activity and has verified all checks were received, endorsed by each Responsible Party and have cleared the bank statement. 2. At the end of each month the DRA will review the RFMS trial balance listing residents names and their account balances. DRA will review the census for each resident that has a savings account. The DRA will notify the Responsible Party for the closing balance plus interest. 3. At the end of each month the DRA will review the RFMS trial balance listing resident names and their account balances. DRA will review the census for each Resident that has a savings account. The DRA will notify the Responsible Party via phone call and/or letter of any remaining balances in the resident's savings account within 30 days of the resident's death. A check will be mailed to the Responsible Party for the closing balance plus interest.	08/31/10 09/01/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ann R. Schiff	Executive Director/Administrator	11/7/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3060 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) COMPLETION DATE
F 160	Continued From page 1 acknowledged the above findings.	F 160	4. At the end of each month the DRA will review the RFMS trial balance listing resident names and their account balances. DRA will review the census for each resident that has a savings account. The DRA will notify the Responsible Party via phone call and/or letter of any remaining balances in the resident's savings account within 30 days of the resident's death. A check will be mailed to the Responsible Party for the closing balance plus interest. Our performance will be monitored by having the DRA and the NHA verify the facility is in the compliance with the POC and is signed off each month. This process will also be implemented into our quality assurance system.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review, personnel file review and staff interview, it was determined that facility staff failed to: review and revise generic abuse policies to reflect their facility practice, failed to provide the updated contact information for reporting to the state agency, and failed to ensure that contract and agency staff received abuse training before providing services to residents in the facility. The findings include: A. When facility policy on abuse was requested facility staff presented this writer with a Policy and Procedure book developed by [Company Name]. A review of this manual lacked documented evidence that the abuse policy presented had been reviewed/ revised or signed off by facility staff. B. A review of contact information for reporting alleged abuse to the State Agency lacked evidence that the contact information had been updated in the last two (2) years to reflect the current contact numbers for the State Agency. C. A review of Abuse policy titled " Reporting Abuse to Facility " revealed the following: " Our Facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies	F 226	**F 226** 1. The facility policy on abuse has been revised, reviewed, and signed off to reflect facility practice on abuse. Agencies and Contractors will be provided a copy of the facility abuse policy and will be required to provide the facility documentation that agency and contract staff have received abuse training and/or have reviewed the facility policy regarding abuse before providing services to residents in the facility. 2. Staffing coordinator will verify that agency personnel have had abuse training or reviewed the facility policy when requesting staffing support. 3. Charge nurses and/or supervisor will review facility abuse policy with agency staff prior to making assignments. 4. Managers will monitor the staffing book to assure that documentation of abuse training/ or review of facility policy was accomplished.	11/05/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 226	Continued From page 2 serving the resident, ... " . A review of personnel records for six (6) of six (6) contract employees regarding inservice training documentation lacked documented evidence that the facility abuse policy had been reviewed or that abuse training had been received before providing services to residents in the facility. Face-to face interviews were held with Employees #1, #2 and #17 on August 31, 2010 in the late afternoon. The above findings were acknowledged by these employees. On September 1, 2010 Employee #1 presented an inservice training packet to be completed by all agency and contract employees before providing services to the residents.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on September 1 and 2, 2010, it was determined that the facility staff failed to provide effective maintenance services in residents' rooms as evidenced by five (5) of 12 dusty bathroom vents and window sills in residents' rooms, one (1) of two (2) missing eyewash solution bottles, questionable temperature log values in rehab, and one (1) of two (2) soiled medication room floor. The findings include: 1. Bathroom vents and/or window sills were dusty in rooms # 171, 173, 182, the clean linen room and bathing room.	F 253	**F253** Bathroom vents were cleaned thoroughly and will be routinely cleaned by the housekeeper on duty. In the Monthly inspections status of vents will be noted and reported to facilities office for correction if needed. Record of findings will be kept in the facilities office and reported at Q.A. No resident was affected by this issue.	9/3/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 253	Continued From page 3 2. The eyewash solution bottle was not available in the clean linen room on the lower level. 3. The temperature of the ice pack equipment in rehab was noted to be zero (0) to five (5) degrees Fahrenheit (F) for the month of August 2010 while the thermometer used to verify that temperature could only measure down to twenty-five degrees F. 4. The floor in the medication room on the upper level was soiled. These observations were done in the presence of Employee #7 who acknowledged the findings at the time of the observation.	F 253	The solution was replaced. Monthly rounds will be conducted to ensure solution is available and has not passed expiration date. Solution will be replaced annually and more often if used. Housekeeping and Maintenance Supervisors will monitor eye wash stations on a monthly basis. Any issues that are found with the station will be reported to the Quality Assurance Committee for resolution. No resident was affected by this issue. No residents were found to be affected by the defective thermometer. The thermometer was replaced the day of the survey. Rehab department replaced the thermometer with a new thermometer that measures to zero (0) degrees Fahrenheit. The temperature of the freezer will be taken daily with the thermometer that measure to zero degrees. The temperature will be logged daily. The floor was thoroughly scrubbed and will be monitored daily by the Housekeeper assigned to the area. Housekeeping Supervisor will randomly check the area for compliance. No residents were affected by this issue.	8/31/10 09/02/10 8/31/10
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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; or an individual who willfully and knowingly causes another individual	F 278	F 278 1. The MDS for resident #3 could not be corrected because the MDS for that assessment was a quarterly MDS, and the two subsequent MDS were coded correctly for allergies and falls.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 278	Continued From page 4 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false 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 facility staff failed to accurately code the Minimum Data Set (MDS) for Resident #3 for allergies and a fall. The findings include: A. Facility staff failed to accurately code Resident #3 for Allergies. Review of a " History and Physical " signed November 12, 2009 revealed: Allergies to Penicillin and Sulfa. A review of the "Physician's Order Sheet and Interim Plan of Care" signed November 9, 2009 revealed, "Allergy History: PCN [Penicillin], Sulfa, Sulfonamide ABT [Antibiotic]." A review of the admission assessment MDS completed November 16, 2009 revealed that the resident was not coded for allergies in Section I (Disease Diagnoses). A review of the resident ' s clinical record lacked other evidence that facility staff had coded the resident for "Allergies" in Section I (Disease	F 278	2. MDS 3.0 effective Oct. 1, 2010. No longer address allergies on the assessment. MDS coordinator and unit managers will continue to assess for allergies to assure care plans are complete and in the medical record. 3. MDS coordinator will review with the DON or designee all falls that occurred prior to assessment period for the resident to obtain and verify that all falls have been documented. 4. DON or designee will randomly audit the MDS to assure complete and accurate information is being assessed and documented on the MDS.	10/1/10

AW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 278	Continued From page 5 Diagnoses) on the admission MDS. A face-to-face interview was conducted on August 31, 2010 at 11:00 AM with Employee #14. He/she acknowledged that the MDS was not coded for allergies. The record was reviewed on August 31, 2010. B. Facility staff failed to accurately code the quarterly MDS for a fall for Resident #3. A review of the Quarterly MDS completed February 12, 2010 revealed that " Section J (4) Accidents " was not coded for any fall(s). Further review of the "Fall Prevention Care Plan" initiated November 12, 2009 revealed, " [November 19, 2009], "Resident was walking in the hallway [with] walker as usual and suddenly fell to the floor. [No] injury noted. Neuro [checks within normal limits]. An "interim order" dated November 19, 2009 at 8:00 PM directed, "[Telephone order [MD], hourly rounds for safety. Rehab referral [secondary] to fall. " The "Nurses Notes" dated November 20, 2009 at 7:10 AM revealed, "S/P [Status Post] fall appear stable. [No] distress or discomfort noted, [no complaint] of pain voiced. Slept all night. Will continue to monitor closely." A review of the physical therapy plan of treatment dated November 30, 2009 revealed, "Reason for Referral: [Decreased] functional mobility,	F 278		

AKS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 278	Continued From page 6 Plan Of Treatment: therapeutic activities, bed mobility training, transfer training, neuromuscular re-education, balance training, gait training, safety education, therapeutic exercise and resident/caregiver train. Frequency [three times a week for thirty] days. " A review of the resident ' s clinical record lacked evidence that facility staff coded the resident for falls in Section J (Accidents) on the quarterly MDS completed February 12, 2010. A face-to-face interview was conducted with Employee #14 on August 31, 2010 at approximately 11:30 AM. After review of the Quarterly MDS he/she acknowledged that the MDS was not coded for fall(s). The record was reviewed on August 31, 2010.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F 279 1. Resident #9 care plan was developed to reflect an intolerance to sulfa. 2. A chart audit was conducted to assure all residents with allergies or intolerance to any meds or foods have a care plan in the medical record. 3. Unit managers will assure that all residents with allergies or intolerance to any foods or meds will have a Care Plan in the medical record. 4. DON or designee will conduct random audits to assure all residents have complete and comprehensive Care Plan in the medical record.	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 279	Continued From page 7 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 15 sampled residents, it was determined that facility staff failed to develop a care plan with appropriate goals and approaches for a resident with an intolerance to sulfa. Resident #9. The findings include: A review of the August 2010 Physician ' s Order Form dated and signed by the physician on August 19, 2010 revealed in the allergy section " Sulfa (Sulfonamide Antibiotics); SULFA CAUSES NAUSEA/VOMITING NOT ALLERGIC BUT INTOLERANT " Original order date June 10, 2010. Review of the June 2010 MAR (Medication Administration Record) revealed the aforementioned statement. Review of the care plans last updated June 22, 2010 lacked evidence of a care plan for Sulfa intolerance. A face-to-face interview was conducted with Employee # 10 on September 1, 2010 at approximately 10:30 AM. After review of the clinical record he/she acknowledged that the record lacked evidence of a care plan with appropriate goals and approaches for an intolerance to Sulfa. The record was reviewed on September 1, 2010.	F 279		
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 334 SS=D	Continued From page 8 IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	**F 334** 1. Resident #11 was given the flu vaccine in October 2010. The facility has an Immunization policy that is in adherence with current recommendations of the Advisory Committee on Immunizations Practices (ACIP) as set forth by the Centers for Disease Control and Prevention (CDC). 2. Unit Managers will audit all resident's charts for immunization consent form or orders for immunization of flu vaccine prior to the start of the flu season. Residents without consent forms will be obtained per facility policy. a. The resident or legal representative will receive education regarding the benefits and potential side effects of flu immunization and this will be documented in the medical record. b. The resident will either receive the flu vaccine or not due to medical contraindications or refusal, and this will be documented in the medical record. 3. Manager will audit residents charts bi-monthly during the flu season to assure flu vaccines are being administered in a timely manner. 4. Manager will review residents charts to verify consent forms and administration of flu vaccine or declination.	11/05/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 334	Continued From page 9 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 15 sampled residents it was determined that facility staff failed to administer the influenza vaccine during the flu season. Resident #11. The findings include: Review of the facility's "Policy # 6.1 "Administration of Flu Vaccine", effective date September 1, 2004 Policy : A Licensed nurse will provide influenza immunizations to employees	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 334	Continued From page 10	F 334		

and residents: under the Medical Director's authorization; with attending physician order/authorization; with resident /health care decision maker/employee consent; in adherence with current recommendations of the Advisory Committee on Immunizations Practices (ACIP) as set forth by the Centers for Disease Control and Prevention (CDC)."

Review of the medical record revealed that the "Immunization Consent & Acknowledgement Form" for Resident #11 was signed and dated October 14, 2002. "Vaccine should be taken annually."

Review of the Physician ' s Order Form for August 2010 revealed in the " Immunizations " section FLU Vaccine 0.5ML X (time) 1 dose annually - October ... " original date November 15, 2008.

Review of the resident ' s immunization record revealed that the Influenza vaccine was last administered on October 11, 2008. The immunization record lacked evidence of that the influenza vaccine was given October 2009.

A face-to-face interview was conducted with Employee #10 on September 1, 2010 at approximately 10:30 AM. After review of the immunization records the Employee #10 indicated that "we do not give the immunizations every year and that there needs to be a new consent form". There was no real clear answer given as to why the influenza was not given in October 2009.

Facility staff failed to administer the influenza vaccine during the flu season. The record was reviewed on September 1, 2010.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the dietary services on August 31, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by five (5) of five (5) slices of cake and two (2) of two (2) pound cakes that were not dated or covered, a crawling pest, two (2) of five (5) drain lines that offered no air gap to the drain, One (1) of three (3) ice machines that was not functioning , a damaged area on the kitchen floor and one (1) of one (1) soiled grill and one (1) of one (1) soiled tilt skillet, and outdated tray tickets that were used to verify residents diet orders. The findings include: 1. Slices of cake were not dated and were stored uncovered in refrigerator #4. Two (2) of two (2) pound cakes were not labeled and stored uncovered in the walk-in freezer. 2. A crawling pest was observed on the kitchen wall. 3. Drain lines from the vegetable sink in the main kitchen and from the ice machine in the first floor kitchen provided no air gap from the drain.	F 371	F 371 (1) 1. Slices of cake were immediately covered and dated 2. In-service training was conducted with the dining staff on 09/12/2010 on how to properly cover and date all food items prior to putting food in the refrigerator. 3. Daily inspections are conducted by the chef's and dining room supervisors to ensure all food items are properly covered and dated 4. Continuous reminders are made at daily stand up meetings 5. No residents were found to be affected by this event. F 371 (2) 1. A service call was made to Ecolab Pest Control Company for immediate treatment treatment. Pest control treatment was conducted on the evening of 9/1/2010 2. No residents were found to be affected by this treatment 3. Daily kitchen inspections are being conducted by the Chefs for any evidence of roaches. 4. Monthly pest control treatments are scheduled and are being conducted by Ecolab Pest Control Company. 5. No evidence of roaches has been found in the kitchen. F 371 (3) 1. A work order was submitted to maintenance to repair the sinks drain pipe to provide an adequate air gap between the pipe and the floor drain. 2. A work order was submitted to maintenance to repair the ice machine drain pipe to provide an adequate air gap between the pipe and the floor drain.	9/12/2010 9/1/2010

ars

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 371	Continued From page 12 4 The ice machine located on the first floor kitchen was not functioning and a repair or replacement work order had not been submitted. 5. Two floor tiles were dented and needed to be replaced in front of the walk-in freezer. 6. The grill and the tilt skillet were soiled and in need of cleaning. 7. Freezer temperatures exceeded allowable limits of zero (0) degrees Fahrenheit (F) during the months of April thru August 2010. 8. Lunch tray tickets dated August 29, 2010 were used to serve residents meals on August 31, 2010. These observations were made in the presence of Employee #6 who acknowledged the findings during the survey.	F 371	3. No evidence of any floor drain backups into the sink and ice machine drain pipe. 4. Repairs were made to both the ice machine and sink floor drain. 5. No residents were found to be affected by this deficiency **F 371 (4)** 1. An out of order sign was placed on the ice machine 2. A work order was submitted to maintenance to repair the ice machine 3. Maintenance repaired the ice machine and it is in good working condition 4. Daily inspections are made by the chefs and dining room supervisors to ensure the ice machine is in proper working condition. If not, they have been instructed to place an out of order sign on the ice machine and submit a work order for repair to the maintenance department. 5. No residents were affected by this event **F 371 (5)** The two floor tiles are constructed to facilitate draining in front of the walk-in freezer. These tiles are not dented or bulked and do not need to be replaced or repaired. No resident is affected by this issue. **F 371 (6)** 1. In-service training was conducted with the culinary staff on 09/15/10 how to properly clean the grill and tilt skillet after each use. 2. Daily inspections are being conducted by the chefs to ensure all equipment is being properly cleaned after each use 3. Continuous reminders about properly cleaning equipment are made at daily stand up meetings	11/04/10 10/29/10 9/15/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 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 facility staff failed to acknowledge the pharmacist's recommendation for Resident #2.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 428	Continued From page 13 The findings include: A review of the clinical record for Resident #2 revealed a Medication Regimen Review [MRR] report from the pharmacist. The report was dated June 2, 2010 and stated, "Resident takes Mirtazapine and Nortriptyline HCL. He/she is receiving Lorazepam 0.5mg at bedtime for anxiety." The report continued that, "a drug interaction exists between the medications with the potential for ... confusion, myoclonus, tremor, agitation, ataxia, restlessness, diarrhea, nausea, diaphoresis and tachycardia." The pharmacist's recommendation stated, "Please consider re-evaluating continued use of these medications concurrently" The review was signed by the pharmacist. Beneath the pharmacist's signature was an area titled "Physician's Response." There were three [3] statements under the area designated for the physician's response. The first statement was "I accept the recommendation(s) above. Please implement as written." The second statement stated, "I accept the recommendation(s) above with the following modification(s) and the third stated, "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below: Rationale:" Neither statement was checked and the area allocated for the physician's signature was left blank. A review of the physician's orders last signed by the physician on August 12, 2010 revealed orders for Mirtazapine and Nortriptyline May 21, 2010 and Lorazepam dated June 23,2010. No adjustment was made to either medication between the date of the MRR [June 2, 2010] and	F 428	4. No residents were found to be affected by this event 5. Evidence of proper cleaning procedures have been noted on the quarterly culinary audits of the kitchen. **F371 (7)** 1. No residents were found to be affected by the incorrect readings of the freezer thermometers. 2. New thermometers were placed into service on 9/3/10 that are capable of reading to zero (0) degrees Fahrenheit or below. 3. Thermometers and now in the coldest spot inside of the freezer to ensure proper temperature readings. 4. Temperature readings are conducted by looking at the internal thermometer not the external thermometer. 5. The freezer temperatures are taken at least 2 times daily and all readings are under zero (0) degrees Fahrenheit. **F371 (8)** 1. A service call was placed to the Tray Tracker computer software company. 2. On 9/20/10 the dietician downloaded the current version of the Tray Tracker software. 3. Daily inspections are made by the dietician and/or dining room supervisor to ensure the correct dates on the ticket. 4. With the current version of the software tray tickets can be printed the night before to properly prepare for the breakfast meal. 5. No residents were affected by this event.	9/3/10 9/20/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 428	Continued From page 14 the date of the survey [September 1, 2010]. A face-to-face interview was conducted with Employee #9 at approximately 11:00 AM on September 1, 2010. He/she acknowledged being aware that the physician failed to respond to the pharmacist's MRR report. He/she added, "The report was addressed to the psychiatrist and when he/she failed to respond to it, we referred it to the primary physician but he/she has not responded either. We are developing a new process for handling the MRR reports which will eliminate the problem." The record was reviewed on August 31, 2010.	F 428	**F 428** 1. Resident #2 pharmacy recommendation was reviewed by the attending and adjustments were made. 2. The DON or designee will monitor the monthly pharmacist report to assure timely compliance of recommendations to attending physicians. 3. All pharmacy recommendations will be forwarded to attending physicians and to consultant physicians and other disciplines as needed. 4. The DON will consult with unit Managers weekly regarding status of pharmacy recommendations until resolved. Recommendations not resolved by attending Physician will be referred to Medical Director for resolution.	11/5/10
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F 431** 1. All expired and discontinued meds were removed from the medication carts on the upper and lower levels. 2. The charge nurses on the 3-11 shift will be responsible for removing all expired and discontinued medications from the carts daily. 3. The RN supervisor will assure the 3-11 Charge Nurse has checked the Med carts and all expired and discontinued meds have been removed and sign checklist verifying this has been done. 4. Managers will randomly check the Checklist to assure this is being done daily.	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 431	Continued From page 15 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to remove expired and discontinued medications from the medication carts located on the Upper Level and Lower Level floor nursing units. The findings include: Expired and discontinued medications were observed on the Upper Level and Lower Level floor nursing units as follows: Upper Level Team 1 cart Twenty-four Oxycodone 5mg/325mg tablets discontinued August 27, 2010 Four (4) Tylenol 325mg tablets expired November 30, 2009 Team 2 cart Seventeen Lorazepam 0.5mg tablets expired June 30, 2010 Four (4) Tylenol 325mg tablets expired August 8, 2010	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 431	Continued From page 16 Lower level Team 1 cart Three (3) Genebs 325mg tablets expired November 15, 2009 Fourteen Trazadone 50mg tablets expired May 31, 2010 Team 2 cart Fifteen Tylenol 325mg tablets expired December 31, 2009 Thirty-five Tylenol 325mg tablets expired October 31, 2009 Seven (7) Tylenol 325mg tablets expired August 15, 2010 Record review and staff interview on August 31, 2010 at 2:00PM revealed that no resident received any of the expired medication found on the medication cart. The above findings for both the Upper Level and Lower Level floor unit were acknowledged by Employees #9 and #15 on August 31, 2010 between 12:15 AM and 2:10 PM.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 441	Continued From page 17 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on September 1 and 2, 2010, it was determined that the facility staff failed to handle clean linen in a manner to prevent the spread of infection in two (2) of two (2) observations. The findings include: Clean linen was	F 441	F 441 1. Curtains are being installed on the shelving in the clean linen room. Until such time all linen will be stored on covered carts. 2. In-service will be held with Laundry and Nursing staff to make sure they understand this practice. 3.Laundry and Nursing staff will continuously monitor as they go in and out of linen room to make sure curtain is closed and cart is covered. Periodically Nursing Supervisor will check the linen room to ensure compliance with regulations.	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 441	Continued From page 18 observed stored uncovered in the clean linen room on both the lower and upper levels. This observation was done in the presence of Employee #7 who acknowledged the findings at the time of the observation.	F 441		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on September 1 and 2, 2010, it was determined that the facility staff failed to ensure that handrails are firmly attached to the wall. The findings include: Handrails located next to the clean linen room on the upper level, rooms #199 and #090 were loose. This observation was made in the presence of Employee #7 who acknowledged the findings at the time of the observation.	F 468	**F 468** Handrails were secured. They will be checked routinely by the maintenance staff during monthly inspections. No residents were affected by this issue.	9/24/10
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469	**F469** After the pest was removed, the table cloth Areas noted were treated on 9/1/10 on an Emergency treatment request. Treatment for the kitchen and pantries remain ongoing, twice monthly. The rest of the facility is treated for pest every Wednesday. No residents were affected by this finding.	9/1/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 469	Continued From page 19 During an observation of the dining area made on August 31, 2010 facility staff failed to keep the dining area free of pest. The findings include: During a dinning observation on August 31, 2010 at approximately 12:31 PM, one (1) of six (6) tables was observed with a crawling black and brown colored pest. After the pest was removed, Employee#11 at 12:50 PM entered the dining area, removed the table cloth and replaced it with a new one. A face-to-face interview was conducted with Employee #1 on September 2, 2010 at approximately 11:00 AM. After review of the circumstances Employee #1 indicated that pest control was called. The observation was made August 31, 2010	F 469		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to comply with District of Columbia regulations as evidenced by failing to complete a history and physical examination for three (3) resident. Residents #4,	F 492	F 492 1. Residents #4, #8, and #11 have current H&Ps, October 2010 2. A chart audit was conducted to determine if any other residents were out of compliance with current H&Ps. Any charts found to be non-compliant will be brought to the attention of the attending physician for immediate correction. If the attending does not respond in a timely manner, the Medical Director will be notified to complete the H&P. 3. The MDS coordinator will Identify the Residents requiring annual MDS Assessment and notify the Unit Managers. Unit Managers will audit those charts identified for all annual assessments including H&P, Nursing assessments. 4. The MDS Coordinator or designee will audit charts due for annual MDS Assessment to assure all annual Assessments are completed prior to submitting MDS to CMS.	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 492	Continued From page 20 8, and 11. The findings include: According to 22 DCMR 3207. 11, "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months and documented in the resident's record." 1. A review of Resident #4's clinical record revealed that the last history and physical examination was documented on May 30, 2009. Further review of the resident's clinical record revealed physician progress notes dated May 12, 2010, June 22, 2010, July 5, 2010, and August 13, 2010. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #4 on September 2, 2010 at approximately 10:00 AM. After reviewing the resident ' s clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident ' s thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2, 2010. 2. A review of Resident #8's clinical record revealed that the last history and physical examination was documented on October 10, 2008. Further review of the resident's clinical record	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 492	Continued From page 21 revealed physician progress notes dated October 27, 2009, November 30, 2009, and December 29, 2009. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #4 on September 2, 2010 at approximately 10:00 AM. After reviewing the resident ' s clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident ' s thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2, 2010. 3. A review of Resident #11's record revealed that the last history and physical examination was documented on November 17, 2008. Further review of the resident's clinical record revealed physician progress notes dated June 22, 2010, July 5, 2010 and August 8, 10, 2010. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #10 on September 2, 2010 at approximately 9:30 AM. After reviewing the resident ' s clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident ' s thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2. 2010	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 15 sampled residents it was determined that facility staff failed to document residents allergies and dislikes on the Lunch tray ticket for one (1) resident. Residents #11 The findings include: 1. Facility staff failed to document Resident #11 ' s dislikes or allergies for chocolate or chocolate flavors on the " lunch tray form ". A review of the " lunch tray ticket " dated September 2, 2010 revealed that the ticket lacked evidence of the resident having any food dislikes or allergies. A review of the resident ' s care plans last updated August 17, 2010 revealed that the resident has an allergy care plan for foods:	F 514	F 514 1. Residents #11 lunch tray ticket was corrected to reflect likes and dislikes. 2. The Dietician will conduct an audit to assure residents likes/dislikes and food allergies are noted on the tray ticket. 3. Upon admission the charge nurse will assure the food likes/dislikes and allergies are noted on the Dietary Slip sent to dietary indicating type of diet. The Dietician will audit charts for new admissions to assure food likes/dislikes and allergies are documented and have been received by Dietary. 4. Dietary department will conduct random audit to assure tray tickets contain correct information regarding Resident likes/dislikes and allergies	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	09/02/2010

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) COMPLETION DATE
F 514	Continued From page 23 chocolate, chocolate flavors. A face-to-face interview was conducted with Employee #8 on September 2, 2010 at approximately 1:30 P.M. A query was made as to the " lunch tray ticket " lacking documentation identifying the allergy to chocolate and chocolate flavors or food dislikes. Employee #8 indicated that the resident " does not have an allergy to chocolate or chocolate flavors, but that she has a dislike for chocolate and chocolate flavors. " After review of the "lunch tray ticket" Employee #8 acknowledged that the form lacked documentation of the food dislike. The record was reviewed on September 2, 2010.	F 514		