Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0001	A. BUILDING _____ B. WING _____	10/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK MANOR NURSING CTR	2131 O STREET NW WASHINGTON, DC 20037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments	L 000		
	The annual licensure survey was conducted on October 6 through 13, 2009. The following deficiencies were based on observations, record review and staff and resident interviews. The sample included 26 residents based on a census of 173 residents on the first day of survey and 26 supplemental residents. Following complaints were investigated: 09-042 [DC00001705], 09-043 [DC00001712], 09-061 [DC00001748].			
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to ensure that an annual comprehensive medical examination was conducted for Resident #12. The findings include: A review of Resident #12's clinical record lacked evidence of an annual comprehensive medical examination for 2009. The record revealed that the last comprehensive medical examination was done on June 24, 2008. A face-to-face interview was conducted with Employee #7 at approximately 11:00 AM on October 8, 2009. He/she acknowledged that the resident has not received a comprehensive physical for 2009. The record was reviewed on October 7, 2009.	L 036	1. The annual comprehensive medical examination (H&P) for resident #12 was later found in the resident's chart on 10/13/09. 2. All other residents' charts were checked by RCCs and found to have up to date H&Ps on 10/30/09. 3a. A weekly chart audit will be done by the RCCs to ensure that residents' H&Ps are done in a timely manner. 3b. All H&Ps found to be nearing their annual due date or at their annual due date will be flagged by RCCs and the primary physician will be notified so that residents' H&P can be done in a timely manner. 3c. Medical records technicians will audit residents' charts monthly for compliance with H&Ps. 4. Deficient practice related to annual H&P will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09

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L 051	Continued From page 1	L 051		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, record review and staff interview of two (2) of 26 sampled residents, it was determined that the charge nurse failed to review and revise care plans after quarterly Minimum Data Set (MDS) assessments. Residents #4 and 13. The findings include: The charge nurse failed to review and revise multiple care plans after periodic assessments for Residents #4 and 13.	L 051	1. Care plans for residents #4and #13 were up-dated to reflect current health status on 10/16/09. 2. All care plans were reviewed on 11/3/09 for updated notes and found to be in compliance.	

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L 051	Continued From page 2 1. A review of Resident # 4's clinical record revealed that he/she had a periodic quarterly assessment completed on March 16, 2009 as evidenced by a signed and dated Minimum data Sets (MDS) . A further review of Resident # 4' s clinical record revealed a " Care Plan Problem List " that listed twenty-one active problems. Nineteen of the listed problems were active and initiated on or before September 2008 and were all updated/evaluated on December 22, 2008 and June 17, 2009. Problem #6 "Weight Maintenance Care Plan"; and Problem #5 "Abnormal Labs Care Plan " were updated/evaluated after the resident was assessed and a quarterly MDS completed on March 16, 2009. The charge nurse failed to review and revise the resident's following multiple care plans after the resident was assessed and a quarterly MDS was completed on March 16, 2009 " Physical mobility, dental, fall prevention, hypertension, risk for constipation, psychoactive drug use, agitation, depression, self care deficit, pain, delusion, non compliance, allergy, territorial behavior, vision, cognitive loss/dementia, dehydration and behavior-hoard. " A face-to-face interview was conducted with Employee #6 on October 17, 2009 at approximately 11:00 AM. After reviewing the resident's clinical record, he/she acknowledged the above findings. He/she added, "It was an oversight." The record was reviewed October 7, 2009. 2. A review of Resident # 13's clinical record	L 051	3a. The interdisciplinary team members were retrained on 10/23/09 on the importance of completing and updating MDS/care plans after each care conference meeting. 3b. Medical records staff will audit care plans monthly to ensure that they are updated. 4. Problems of not updating care plans will be reported to the DON, AA/QA for remedial action and discussed in the Monthly Risk Management/QA and Quarterly QA meetings.	11/27/09

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L 051	Continued From page 3	L 051		
	revealed that the charge nurse failed to update and/or revise the resident's plan of care on March 19, June 18, and September 14, 2009 as evidenced by the signed and dated respectively quarterly, annual and quarterly MDS. A further review of the resident's clinical record revealed that the following multiple care plans were not updated and revised /evaluated after the resident was assessed and a quarterly MDS completed on March 19, 2009. "Cognitive loss/dementia, psychoactive drug use, self care deficit, vision, incontinence, fall prevention, dental, 9+ medication, diabetes, allergy, dehydration risk, aspiration risk, anticoagulation, seizure disorder, risk for pressure ulcer. " The charge nurse failed to review and revise Resident #13's multiple active care plans after the resident was assessed and a quarterly MDS completed on March 19, 2009. A face-to-face interview was conducted with Employee #6 on October 17, 2009 at approximately 3:40 PM. After reviewing the resident's clinical record, he/she acknowledged the above findings. He/she added, "It was an oversight." The record was reviewed October 7, 2009.			
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;	L 052		

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(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:

(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;

(d) Protection from accident, injury, and infection;

(e)Encouragement, assistance, and training in self-care and group activities;

(f)Encouragement and assistance to:

(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:

A. Based on observation, staff interview and

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L 052	Continued From page 5	L 052	1a. The facility clarified that resident #11 was not on hospice care. 1b. The resident was re-screened on 10/12/09 and admitted for PT, OT and ST. 2. All other resident physician orders were reviewed on 11/5/09 for rehabilitation services and found to be in compliance. 3a. A weekly chart audit will be conducted by the RCC to ensure that orders for rehabilitation services are done per physician's orders. 3b Licensed staff will be in-serviced on 11/6/09 on the importance of reviewing physician orders to ensure that orders for rehabilitation services are followed-up in a timely manner. 4. Deficient practice related to rehab services and physician orders will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09

record review for one (1) of 26 sampled residents, and one (1) of 26 supplemental residents, it was determined that rehabilitation services failed to follow-up on a physician's order for therapy for one (1) resident and licensed staff failed to assess a residents' apical pulse prior to the administration of an antiarrhythmic medication in one (1) of 42 medication pass opportunities. Residents #11 and K1.

The findings include:

1. Facility staff failed to provide sufficient nursing time to follow-up on a physician's order for rehabilitation services. Resident # 11.

A review of Resident record revealed an order on the " Admission Order Sheet and Physician Plan of Care " dated July 7, 2009 that read, " Screen: Physical Therapy and Occupational Therapy " .

A review of the " Interdisciplinary Resident Rehab Screen Sheet" revealed a note dated July 21, 2009 that read, Patient is currently on hospice Patient not a rehab candidate. "

A review of admission note dated July 20, 2009 at 8:00 PM reads. "Resident is admitted for palliative care. According to hospital papers the family has opted for hospice care however [attending physician] holds a different view. Resident care coordinator to follow up with [attending physician]. "

A review of resident record revealed no record of resident being admitted to hospice care at facility.

A face-to-face interview was conducted with Employee #30 on October 8, 2009 at 2:15 PM. He/she stated that resident was screened on

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	admission but because he/she was hospice he/she was not a rehab candidate. The record was reviewed October 8, 2009. 2. Facility staff failed to provide sufficient nursing time to obtain an apical pulse prior to administering Digoxin for Resident K1. An observation during the medication pass conducted on October 8, 2009 between 8:00 AM and 8:30 AM on the 2nd floor nursing unit revealed that the nurse administered an antiarrhythmic medication without assessing Resident K1's apical pulse. A review of Resident K1's clinical record revealed physician's orders dated August 17, 2009 that directed " Digoxin 0.125mg, one (1) tablet by mouth daily for congestive heart failure. " A review of the Medication Administration Record for October 2009 revealed Digoxin was scheduled for administration at 8:00 AM daily. During the medication pass observation, the nurse was observed preparing resident K1's medications, one of which included Digoxin 0.125 mg. He/she offered the resident a cup of water and the medications. The resident swallowed the pills and the nurse verified that the resident swallowed the medications. As the resident departed, the nurse was queried regarding the resident's vital signs. He/she stated that vital signs were not obtained. The nurse immediately asked the resident to return to his/her room so that vitals could be assessed. The nurse was observed auscultating the resident ' s apical pulse. The result was 82 beats per minute.		1a. Resident #K1 was not harmed by the deficient practice. 1b. The resident's apical pulse was checked on 10/9/09 and found to be within normal range. 1c. The licensed staff was re-trained on 10/24/09 on the importance of checking apical pulse before the administration of Digoxin. 2. The MARs of all residents receiving digoxin were reviewed on 10/30/09 for apical pulse documentation and found to be in compliance. 3a. Licensed staff were re-in-serviced on 10/30/09 on the importance of vital sign assessment before the administration of an antiarrhythmic medication. 3b. Random medication pass audit will be conducted with the charge nurses on a quarterly basis and PRN to ensure accuracy of medication administration. 4. Problems related to the resident's Medication administration will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09

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L 052	Continued From page 7	L 052	1a. Resident #5 was referred to rehab services for screening and evaluation for a decreased ROM on 10/14/09. 1b. Resident #5 was admitted for rehabilitation therapy on 10/15/09. 2. Quarterly MDS assessments were reviewed for decline in range of motion on 11/5/09 and found to be in compliance. 3a. The RCC will audit of the residents' ADL flow sheets and MDS quarterly to ensure that any significant decrease in a residents' ADLs is referred to rehabilitation for screening. 3b. A weekly audit of the resident's chart will be conducted by the RCCs to ensure that all physician orders are followed. 3c. Residents will be screened by the rehabilitation department quarterly during their assessment period. 4. Problems related to rehabilitation services and physician orders will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09
	B. Based on record review and staff interview for one (1) of 26 sampled residents, it was determined that facility staff failed to provide appropriate treatment and services to maintain or improve his or her abilities for Resident #5. The findings include: Facility staff failed to give appropriate treatment and service to maintain and or improve Resident #5's Range of Motion to his/her neck. A review of the Minimum Data Sets revealed the following: The quarterly MDS completed March 27, 2009 Section G4 [Test for Balance] neck, arm and hand was coded as no limitation or voluntary movement; The quarterly MDS completed June 22, 2009 and the annual MDS completed September 14, 2009 Section G4 neck was coded as Limitation on one side and partial loss. The record lacked documented evidence that rehabilitative and/or restorative services were provided to Resident #5 after the functional limitation in range of motion was assessed/identified. A face-to-face interview was conducted on October 13, 2009 at 9:15 AM with Employee #6. He/she acknowledged that Resident #5 did not receive any rehabilitative and/or restorative services after the noted decline in the functional limitation in range of motion to the neck. The record was reviewed on October 13, 2009.			
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and	L 099		

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L 099	Continued From page 8	L 099	1. The outdoor grill was cleaned on 10/6/09.	
	served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on October 6 through 9, 2009 during the tour of dietary services, it was determined that the facility failed to prepare and distribute food under sanitary conditions as evidenced by a soiled outdoor grill stored in the main dining room; a soiled floor in the main kitchen; and water leaking from the ceiling in the main kitchen. These observations were made in the presence of Employee #10. The findings include: 1. The outdoor grill stored in the main dining room and was observed to be soiled with food residue in one (1) of one (1) outdoor grill observed. 2. The kitchen floor was soiled and in need of cleaning in one (1) of one (1) observation. 3. Water was leaking from the ceiling in the dishwashing area in one (1) of one (1) observation. These findings were acknowledged by Employee #10 at the time observation.		2. All dietary related equipment were checked on 10/14/09 for cleanliness and were found to be in compliance. 3a. In-service on how to properly clean the outdoor grill was given to dietary and therapeutic recreation staff on 10/14/09. 3b. The Director of Food Services and Director of Therapeutic Recreation will conduct daily a overall cleanliness of the outside grill for compliance. 4. Problems relating to cleaning the outside grill will be reported immediately to the Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for further remedial action.	11/27/09
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by:	L 108		

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L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by:	L 108		

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L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by:	L 108		

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L 108	Continued From page 9	L 108	1a. Resident was not harmed by the deficient practice. 1b. Food for the affected residents were reheated. 2 . Residents' food temperature was checked on the unit on 10/14/09 and found to be in compliance with temperature range of equal or greater than140°F for hot food. 3a. Food temperature will be monitored weekly to assure correct temperature when they arrive on the unit. 3b. Both nursing and Dietary staff were in-serviced on 10/21/09 on the correct serving food temperatures on unit and the reheating of foods as needed. 3c. Elevator #3 will be on reserve at meal times to ensure a quick meal delivery to the units. 3d. Testing for adequate food temperatures will be conducted daily by the Food Service Director on the test tray on the unit. 4. Problems relating to temperature of food arriving on unit will be reported immediately to ADON, and discussed in monthly Risk Management and Quarterly QA meetings for further remedial action.	11/27/09
	Based on observations and staff interview, it was determined that facility staff failed to ensure that the temperature of cold foods did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. The findings include: A test tray was conducted on October 9, 2009 at approximately 1:00 PM. The hot food temperatures were less than the required 140 degrees on the following items: Fried Catfish was 124 degrees F (Fahrenheit) Lima beans were 130 degrees F Green beans were 132 degrees F These findings were acknowledged by Employee #10 at the time observation.			
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;	L 128		

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L 128	Continued From page 10	L 128		
	(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to properly store one(1) of one (1) bottle of Xalatan medication in accordance with the manufacturer's specifications. The findings include: According to the Manufactures specifications for Xalatan, " ...Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C (77 degrees) for up to 6 weeks." On October 6, 2009 at approximately 3:50 PM, during the inspection of the medication cart, one (1) opened bottle of Xalatan solution was observed in medication cart without an open date. A face-to-face interview conducted at the time of the observation with Employee #27. He/she was unable to determine how long the bottle of Xalatan had been open and acknowledged that the Xalatan bottle was not dated when opened.		1a. The Xalatan eye drops was discarded and a new bottle of Xalatan eye drops was obtained and dated on 10/7/09. 1b. Resident #F1 was not harmed by the deficient practice. 2. RCCs checked all residents' medication including eye drops and found them to be in compliance with dating of opened vials on 10/30/09. 3a. A weekly check of the residents' medications to include eye drops will be conducted by the RCCs to ensure that all medications are labeled and stored properly and per manufactures guidelines. 3b. The licensed nurses were re-in-serviced on 10/23/09 on the dating and the administration of multi dose vial medication. 4. Problems relating to storage, labeling and administration of medication will be reported to DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09
L 179	3229.1 Nursing Facilities The facility shall provide social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	L 179		

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L 179	Continued From page 11	L 179		
	This Statute is not met as evidenced by: Based on staff interview and record review for one (1) of 26 sampled residents, the social worker failed to assess and/or document the psychosocial status for Resident #11 with a communication language barrier. The findings include: A review of the clinical record revealed that the social worker failed to assess and/or document the resident's psychosocial needs since admission date of July 20, 2009. A review of the admission "social worker progress note" dated July 28, 2009 at 1:25 PM revealed, "...Social worker met with resident for initial assessment. Resident was admitted on July 20, 2009. This worker was out of facility on vacation at the time of admission. Met with resident. Resident was up in Geri-chair. Reviewed resident record. Resident has expressive aphasia. Resident looked at social worker but was unable to express and answer questions. Discussed resident in IDT for initial assessment. According to IDT members [family member] is very supportive. Will contact [family member] to assist with admission paperwork..." A review of nurse's note revealed that resident's [family member] visited facility on the following dates: 7/21/2009, 7/22/2009, 7/23/2009, 7/25/2009, 7/26/2009, 7/31/2009, 8/2/2009, 8/4/2009, 8/7/2009, 8/16/2009, 8/28/2009, 9/14/2009 and 9/18/ 2009. Although the [family member] was present in the facility on the aforementioned dates, the clinical		1a. Resident #11 was not harmed by deficient practice. 1b. The residents psychosocial assessment was completed on 10/29/09. 2. Social Workers will audit charts to ensure that all psychosocial assessments are completed and up to date. Completion date 11/18/09. 3a. Social Workers were in-serviced by the social worker consultant on the time frame to complete psychosocial assessments on 10/30/09. 3b. Medical records staff will continue with a monthly audit to ensure completion of initial and quarterly psychosocial assessments. 4. Problems related to the accurate/timely completion of psychosocial assessments will be reported to the Administrator and addressed in the monthly Risk Management/QA and Quarterly QA meeting for remedial actions.	11/27/09

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L 179	Continued From page 12	L 179		
	record lacked evidence of the social worker's attempts contact the family to further assess the residents' psychosocial status for the initial assessment and to complete paperwork. A face-to-face interview was conducted with Employee #15 on October 7, 2009 at 2:00 PM. He/she acknowledges that resident's [family member] was called and message left but he/she has not been able to contact or speak with the [family member]. The record was reviewed October 8, 2009.			
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: A. Based on observations made during a tour of the rehabilitation area, it was determined that the facility failed to ensure that the residents environment was free from accident hazards as evidenced by a fire extinguisher was stored unsecure in the resident area and a computer monitor was stored on the heater in the hallway. These observations were made in the presence of Employee #30. The findings include: 1. A fire extinguisher was stored unsecured on a table in the treatment area in one (1) of one (1) fire extinguisher observed in the rehabilitation area. 2. A computer monitor was stored directly on the heater in the hallway located across from the	L 214	1. The Fire extinguisher located in the rehabilitation service office was re-mounted on the wall on 10/8/09. 2. Fire extinguishers throughout the facility have been checked on 10/8/09 by the Director of Maintenance and found to be in compliance. 2. Fire extinguishers will be checked weekly during Grand Rounds by the Director of Maintenance for continued compliance. 4. Deficient practices relating to fire extinguishers will be reported to the DON unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. 1. The Computer monitor that was found on the 6th floor rehabilitation area was removed on 10/9/09 for appropriate storage. 2. No other unused computer monitor is present in the rehabilitation services area	11/27/09

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L 214	Continued From page 13	L 214		
	elevators on the 6th floor. These findings were acknowledged by Employee #30 at the time of the observation. B. Based on observations made during an environmental tour of the facility on October 6 and 7, 2009, it was determined that the facility failed to properly maintain the physical environment as required as evidenced by 14 of 50 exhaust vents not functioning properly in resident rooms. The observations were made in the presence of Employee #12. The findings include: 1. The exhaust vents were observed not functioning in residents rooms on the west side of the facility in 14 of 50 resident rooms observed. Rooms #117, 119, 120, 218, 219, 221, 319, 320, 417, 419, 420, 517, 518, and 520. The findings were acknowledged by Employee #12 at the time of the observations.		3a. Director of Rehabilitation services in-serviced staff on proper disposal of hazardous items on 10/29/09. 3b. Director of Rehabilitation services will conduct weekly rounds for continued compliance. 4. Deficient practices related to the disposal of old computers will be reported to the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings. 1. Exhaust vents in residents rooms #17, 119,120,218,219,221,319,320,417,419, 420,517,518, and 520 were restored to service on 10/10/09. 2. Exhaust vents throughout the facility have been checked by the Director of Maintenance and found to be in compliance. 3. Exhaust vents will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance. 4. Deficient practices relating to exhaust vents will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09 11/27/09
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on the environmental tour conducted on October 6 and 7, 2009 between 9:00 AM and 10:30 AM, it was determined that the facility failed to provide effective housekeeping and maintenance services as evidenced by: Privacy curtains that were loose in 19 of 50 resident rooms; damaged privacy curtains in four (4) of 50	L 410		

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L 410	Continued From page 14 resident rooms; dusty air vents and soiled walls in five (5) of five (5)shower rooms; damaged ceiling tiles in two (2) of five (5) resident shower rooms; and damaged blinds and soiled walls in the rehabilitation room. These observations were made in the presence of Employees #12 and 30. The findings include: 1. Privacy curtain tracks were loose in 19 of 50 resident's rooms observed; rooms 102, 103, 108, 110, 114, 115, 117, 119, 120, 203, 204, 206, 210, 212, 213, 214, 218, 219, and 221. 2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319. 3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed. 4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed. 5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area. 6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed. The findings were acknowledged by Employees #12 and 30.	L 410	1. Loose privacy curtain tracks will be secured and completed by outside contractor by 11/27/09 for residents in rooms 102,103,108,110,114,115,117, 119,120,203,204,206,210,212,213,214, 218,219 and 221**(See attachment III).** 2. All privacy curtain tracks were checked on 10/19/09 and found to be in compliance. 3a. The Director of Environmental Service and the Maintenance Director will monitor all privacy curtain tracks during weekly grand rounds to ensure they are secured. 3b. Loose curtain tracks will be checked and recorded by housekeeping technicians in the maintenance log for quick repairs by maintenance. 4. The Director of Environmental Service will report problems of loose privacy curtain tracks to the Administrator and discussed in the monthly Risk Management/QA and Quarterly QA meetings for remedial action.	11/27/09
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and	L 426		

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L 410	Continued From page 14	L 410		
	resident rooms; dusty air vents and soiled walls in five (5) of five (5)shower rooms; damaged ceiling tiles in two (2) of five (5) resident shower rooms; and damaged blinds and soiled walls in the rehabilitation room. These observations were made in the presence of Employees #12 and 30. The findings include: 1. Privacy curtain tracks were loose in 19 of 50 resident's rooms observed; rooms 102, 103, 108, 110, 114, 115, 117, 119, 120, 203, 204, 206, 210, 212, 213, 214, 218, 219, and 221. 2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319. 3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed. 4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed. 5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area. 6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed. The findings were acknowledged by Employees #12 and 30.		1a. The damaged privacy curtains in rooms 114,117,301 and 319 will be replaced on 11/15/09. 1b. Contract bids are taken to get a proposal to replace all privacy curtains on the 1st and 3rd floors **(See attachment IV).** 1c. Room 319 is a private room and never had a privacy curtain. 2. Privacy curtains for other residents have been assessed and will be replaced or repaired as needed by 11/27/09.. 3a. The Director of Environmental Service will monitor and check all privacy curtains to ensure they are clean and in good condition. 3b. Housekeeping technician will be trained to check for damaged privacy curtains to be reported to the Director of Environmental Services. 4. The Director of Environmental Service Will submit problems with torn privacy curtains to the Administrator for remedial Action and will be discussed in the Risk Management/QA meeting and Quarterly QA meeting.	11/27/09
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L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and	L 426		

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L 410	Continued From page 14 resident rooms; dusty air vents and soiled walls in five (5) of five (5)shower rooms; damaged ceiling tiles in two (2) of five (5) resident shower rooms; and damaged blinds and soiled walls in the rehabilitation room. These observations were made in the presence of Employees #12 and 30. The findings include: 1. Privacy curtain tracks were loose in 19 of 50 resident's rooms observed; rooms 102, 103, 108, 110, 114, 115, 117, 119, 120, 203, 204, 206, 210, 212, 213, 214, 218, 219, and 221. 2. Privacy curtains were damaged in four (4) of 50 resident's rooms observed, rooms #114, 117, 301 and 319. 3. Air vents were dusty and walls were soiled in five (5) of five (5) shower rooms observed. 4. Ceiling tiles were damaged in the first and third floor shower rooms in two (2) of five (5) shower rooms observed. 5. Blinds were observed to be damaged in three (3) of five (5) blinds observed in the rehabilitation area. 6. Soiled walls were observed in the rehabilitation area in one (1) of one (1) rehabilitation area observed. The findings were acknowledged by Employees #12 and 30.	L 410	1. First-and-third-floor damaged ceiling tiles located in the shower rooms were repaired on 10/13/09. 2. Ceilings tiles through out the facility have been checked by the Director of Maintenance and found to be in compliance on 10/13/09. 3. Ceiling titles will be checked daily and weekly during Grand Rounds by the Director of Maintenance for continued compliance. 4. Deficient practice related to damaged Ceilings will be reported immediately to the Director of Maintenance unto the Administrator for remedial action and discussed in the monthly Risk Management /QA and Quarterly QA meeting.	11/27/09
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK MANOR NURSING CTR	2131 O STREET NW WASHINGTON, DC 20037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 426	Continued From page 15 rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during the recertification survey, it was determined that the facility failed to maintain a pest free environment as evidenced by flying pest observed throughout the entire facility and crawling pests observed on one (1) of five (5) nursing units. The findings include: 1. Flying insects were observed throughout the entire facility during the five (5) day recertification survey. 2. On one (1) of five (5) nursing units observed, it was determined facility staff failed to maintain a pest free environment as evidenced by the presence of crawling pests. On Tuesday, October 6, 2009 at 11:30 AM, a brown crawling pest was observed on the floor at the fifth floor nurses' station. On Wednesday, October 7, 2009 at 2:30 PM a brown crawling pest was observed on the 5th floor nurses' station crawling on the desk. The findings were made in the presence of Employee #9.	L 426	1a. The 5th floor nursing station was treated for pest control on 10/19/09 by the Western Pest Company. 1b. All nursing stations were treated on 10/19/09 and found to be in compliance. 2. The entire facility was checked and treated for pest control on 11/2/09. 3a. Facility staff were in-serviced on 10/24/09 to report pest control issues in the pest control log book. 3b. Compliance meeting was held with the supervisor from the Western Pest Company on 11/3/09 on plans to control pest in the entire facility **(See attachment V I).** 3. Problems relating to Pest Control will report to the Director of Environmental Services unto the Administrator for remedial action and discussed in the monthly Risk Management/QA and Quarterly QA meetings.	11/27/09