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 _____	11/14/2008

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

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L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on a review of incident/unusual occurrence reports from August through November 2008 and staff interview, it was determined that facility staff failed to report to the State Agency one (1) of one (1) injury of unknown origin, four (4) of four (4) falls with injury, and the results of two (2) of two (2) alleged abuse investigations. Residents #6, 19, 22, S1, S2, S3, S4 and S5. The findings include: 35 incident/unusual occurrence reports were reviewed from August through November 2008 and included the following:19 falls with no injuries, six (6) newly opened skin areas, three (3) behavior incidents, four (4) falls with injury and three (3) investigations of alleged abuse. A face-to-face interview was conducted with Employees #1 and 2 on November 13, 2008 at approximately 11:30 AM. Both employees acknowledged that the incidents and/or follow-up reports for the following incidents had not been sent to the State Agency. A. On September 5, 2008, Resident #6 was observed with a swollen left hand, origin unknown. The resident was subsequently diagnosed with a fractured wrist. An investigation was conducted by facility staff. There was no	L 001	1a. No resident was harmed by the deficient practice. 1b. The incident report for resident #6 was faxed to the state survey agency on 10/24/08. 1c. Incident reports for resident #2 and #3 were faxed to the state survey agency on 10/6/08. 1d. Incident reports for residents #19, #22, #S1, #S4 and #S5 were given to the State survey agency on 11/13/08. 1e. Investigation results on incidents for residents #6, #S1, #S2 and #S3 were given to the state survey agency on 11/13/08. 2. All incident/accidents were reviewed and audited and no other deficient practices were noted. 3a. A weekly random audit will be conducted on incident/accident reports by the DON or designee to ensure that all reports of incidents/accidents are communicated by phone or faxed to the DOH within 8 hours and 48 hours respectively. 3b. The facility's policy was updated on 12/11/08 to emphasize incidents/accidents investigation and reporting to state survey agency. 3c. An in-service was given to nursing supervisors on 11/25/08 on the policy and procedure of reporting incidents/accidents to related state survey agency.	

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L 001	Continued From page 1 evidence that the incident was reported to the State Agency. B. On October 25, 2008, Resident #19 was observed by staff sitting on the floor by the side of the bed. On assessment, the resident was observed with a 9 cm (centimeter) x 1.8 cm red area on his/her right side. There was no evidence that this incident was reported to the State Agency. C. On September 23, 2008, Resident #22 was observed on the floor and sustained a laceration on his/her nose and forehead. There was no evidence that this incident was reported to the State Agency. D. Resident S4 was observed on the floor in front of a wheelchair on October 9, 2008. On assessment, there was a bump noted on the right side of his/her head. There was no evidence that the incident was reported to the State Agency. E. Resident S5 was eased to the floor during incontinent care on October 31, 2008. The resident complained of soreness of the mid back area. X-rays of the thoracic spine were negative for fracture. There was no evidence that the incident was reported to the State Agency. F. On October 16, 2008, Resident S1 complained that a CNA (certified nursing aide) handled him/her roughly. An investigation was conducted, which included copies of statements by the resident and staff that were on duty on the date of the incident. According to the " Incident Report/Unusual Occurrence Report - Future Preventative/Corrective Action: Per resident and family request, no male caregivers are to provide care for [Resident S1] ... " There was no	L 001	4. Problems relating to resident incidents/ accidents, investigation and reporting will be discussed during the Daily QA meeting, Monthly, Fall Incident Prevention meeting, Risk Management/QA and Quarterly QA meetings for further remedial action.	12/18/08

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L 001	Continued From page 2 evidence that this incident and the result of the facility's investigative report were reported to the State Agency. The resident was discharged from the facility on November 6, 2008. G. On October 4, 2008, Resident S2 (female) alleged that Resident S3 (male) inappropriately touched her breasts and buttock. The incident was investigated by facility staff. There was no evidence that the result of the facility's investigation was sent to the State Agency. A face-to-face interview was conducted with Resident S2 on November 15, 2008 at 1:45 PM. Resident S2 stated that he/she did not remember the incident and that he/she had never had any trouble with any other resident.	L 001		
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	L 051		

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L 051	Continued From page 3 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 record review and staff interview for three (3) of 26 sampled residents it was determined that charge nurse failed to develop a care plan with appropriate goals and approaches for two (2) residents for potential adverse interaction of the use of nine (9) or more medications; and failed to notify the physician of abnormal labs results for one (1) resident. Residents #2, 3, and 18. The findings include: 1. The charge nurse failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for Resident #2. A review of the Physician's Order Sheet (POS) for October 2008, signed by the physician on September 13, 2008, revealed the following medication orders: Avandia, Docusate Sodium, Ibuprofen, Lisinopril, Lorazepam, Megastrol, Multivitamins, Norvasc, Seroquel and Synthroid. A review of the care plans that were last updated on October 10, 2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #3 at approximately 3:00 PM on November 12, 2008. He/she acknowledged that the record lacked a care plan for the potential	L 051	1a. No resident was harmed by the deficient practice. 1b. Care plan were immediately initiated for 9+ medication for residents #2 and #3. 2. All residents' charts for 9+ medications care plans were reviewed on 11/26/08 and found to be in compliance. 3a. Resident Care Coordinators (RCCs) were re-in-serviced on 11/26/08 by the MDS coordinator on initiating care plans for 9+ medications. 3b. MDS coordinator will monitor for coding and care plans compliance using care plan/MDS audit tool.	

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L 051	Continued From page 4 adverse interaction of the use of nine (9) or more medications. The record was reviewed on November 12, 2008. 2. The charge nurse failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for Resident #3. A review of significant change MDS signed and dated August 28, 2008 coded resident to be on 10 medications under Section O1[Number of Medications]. A review of the August 2008 " Physician Order sheet" signed and dated August 8, 2008, revealed that Resident #3 received the following routine and PRN (as needed) medications: Abilify, Depakote, Lantus, Synthroid, Glucophage XR, Seroquel, Sorbitol Sol 70%, Thiamine HCL, Ativan, Acetaminophen, and Mobic. A review of August 2008 "Medication Administration Record (MAR)" revealed that Resident #3 receives 11 medications as follows: Abilify, Depakote, Synthroid, Glucophage XR, Seroquel, Thiamine HCL, Ativan, Acetaminophen, Sorbitol Sol 70%, Lantus and Mobic. A review of the care plans last updated on October 10, 2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with the Employee #7 on November 13, 2008 at 10:30 AM. He/she acknowledged that there was no care plan for the potential adverse interaction for	L 051	4. Problems relating to care plans will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA meetings for immediate remedial action.	12/18/08

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L 051	Continued From page 5 the use of nine (9) or more medication. The record was reviewed on November 13, 2008. 3. The charge nurse failed to notify the physician of abnormal labs results for Resident #18. The policy entitled, "Labs Results" [no policy number or date documented] stipulated, "Procedure: ...2. Charge Nurse should review all reports and immediately notify the physician of abnormal lab results..." A review of the labs results revealed the following: September 2, 2008- Phenytoin 22.0 [out of range], 10 - 20 [reference range] September 4, 2008- Phenytoin 25.0 [out of range], 10 - 20 [reference range] September 8, 2008- Phenytoin 21.7 [out of range], 10 - 20 [reference range] A review of the lab result forms and the nurses' notes lacked evidence that the physician was notified of abnormal labs immediately. A face-to-face interview was conducted on November 14, 2008 at 3:00 PM with Employees #1 and 2. They acknowledged that the physician was not notified of the abnormal labs immediately. The record was reviewed on November 14, 2008.	L 051	1a. The dilantin dosage for resident #18 was decreased during his hospitalization. 1b. The attending physician gave new orders on 11/20/08, to reflect a decrease in the dosage of the Dilantin. 2. Laboratory results of residents receiving Dilantin were reviewed by the ADON on 12/6/08 and all were in compliance with regards to physician notification 3a. Licensed nursing staff were in-serviced on 11/22/08 on physician notification of abnormal labs. 3b. RCCs including Nursing Supervisors will Review all laboratory results to ensure that physicians are immediately notified of abnormal lab results. 4. Problems related to abnormal labs will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA Meetings.	12/18/08
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	L 052		

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L 052	Continued From page 6 rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (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.	L 052		

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L 052	Continued From page 7 This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of seven (7) residents observed during medication pass, and one (1) of 26 sampled residents, it was determined the facility staff failed to provide sufficient nursing time to: obtain a physician's order for one (1) resident who had medication stored at the bedside; and failed to adequately monitor one (1) blind resident who sustained several falls. Residents JH1 and #17. The findings include: 1. Facility staff failed to provide sufficient nursing time to obtain a physician's order for Resident JH1 who had medication stored at the bedside. Facility's policy and procedure 4.3, "Bedside Storage of Medication", stipulates, "(5) A written doctor's order for the bedside storage of medication is placed in the resident's medical record. " On November 12, 2008, at approximately 10:00 AM, during the morning medication pass, Over-the-Counter (OTC) drugs were observed stored in Resident JH1 ' s room. These OTC drugs were Fungoid tincture, Biofreeze roll-on, Clotrimazole 1% cream and Antacid liquid. A review of the resident ' s October 2008 medication orders, signed by the physician on October 20, 2008, did not have these drugs listed on the medication orders. A face-to-face interview was conducted on November 12, 2008, at the time of the observation with Resident JH1. He/she stated that a family member brought the OTC medications to the facility.	L 052	1a. Resident #JH1 was not harmed by the deficient practice. 1b. The resident was educated on 11/14/08 on the risk of having medication at the bedside and the use of unauthorized medication as documented in the resident's chart. 1c. The attending physician saw resident on 11/17/08, gave orders for self administration of over-the-counter medication, but resident declined the responsibility of self administration of medication. Hence the physician's order for the medication was discontinued. 2. All residents' charts were checked on 12/9/08 for medication administration and proper physicians orders and were found to be in compliance. 3a. All licensed nursing staff were re-in-serviced on 11/25/08 on self administration of medication and the importance of a physician order with regards to medication administration. 3b. The facility will educate all residents' during IDT, Resident Council Meeting and upon admissions that all medications must have physician order prior to administration. 3c. RCCs will spot check residents' rooms for improper storage of medication without physician orders during the AM rounds.	**Ongoing**

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L 052	Continued From page 8 A face-to-face interview was conducted on November 12, 2008, at the time of the observation with Employee #12. He/she stated that he/she did not know the Resident had medication in the room; he/she usually works on another floor. Record reviewed on November 12, 2008. 2. Facility staff failed to provide sufficient nursing time to adequately monitor a blind Resident #17 who sustained several falls. Three (3) observations of the resident's room and environment were made on November 14, 2008 at 8:25 AM, 9:35 AM and 9:50 AM. The resident's call light was wrapped around the arm of a chair at the resident's bed side during each observation. During the 9:35 AM observation, Resident #17 was asked whether he/she knew the location of his/her call bell. He/she responded by using his/her hand to feel for the call bell the bed, and responded "I don't know." when the call bell could not be located. A review of the clinical record revealed a report of an Ophthalmology consult dated August 30, 2007 with a diagnosis of "Blindness". A review of the nurses' notes revealed the following: On May 6, 2008 the resident had a fall without injury. On June 12, 2008 the resident had a fall without injury and on October 23, 2008, "[Resident] complained of pain to right hip. Told nurse he/she fell while trying to get to the bathroom." An x-ray was conducted on October 23, 2008 and revealed no injury. A review of the "Falls Prevention" care plan last updated November 6, 2008 revealed,	L 052	3c. RCCs will spot check residents' rooms for improper storage of medication without physician orders during the AM rounds. 4. Problems related to medication administration and improper storage of medication will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA meetings for immediate remedial action. 1. No resident was harmed by the deficient practice. 2. All resident call bells were checked for access and no deficient practices were noted 3a. Team leaders (CNAs) will conduct a periodic check of residents' rooms to ensure that all call bells are within the residents' reach. 3b. An in-service education was given to all levels of nursing staff on 12/11/08 relating to the importance and use of the call bells by all residents to include residents with blindness. 4. Problems relating to call bells will be discussed during Daily/Monthly Risk Management/QA meeting and in the Quarterly QA meeting for further remedial action.	12/18/08 12/18/08

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L 052	Continued From page 9 "...Approaches/Interventions...5. ...Use call bell for assistance PRN..." The facility lacked adequate monitoring/supervision for Resident #17 with a diagnosis which included Blindness and a history of falls. On November 14, 2008 at 9:50 AM [the third observation] Employee #4 was present and acknowledged that the call light was wrapped around the arm of the chair and out of the reach of the resident. The record was reviewed on November 14, 2008.	L 052		
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 November 11, 2008 from 11:30 AM through 4:00 PM, it was determined that facility staff failed to maintain the shower rooms on all resident units in a clean and sanitary manner. These observations were made in the presence of Employees #8 and 9. The findings include: Five (5) of five (5) shower rooms were observed with cracked and soiled caulking, and/or damaged ceilings. Employees #8 and 9 acknowledged these findings at the time of the observations.	L 410	1. Cracked, soiled caulking and damaged ceilings in all shower rooms were repaired on 11/13/08. 2. All shower rooms were checked by the director of Maintenance on 11/10/08 and were found to be in good repairs. 3a. Maintenance aides were re-in-serviced on 11/26/08 on surveillance rounds to detect cracked, soiled caulking and damaged ceilings in shower rooms for immediate repairs. 3b. Shower rooms will be checked daily by CNAs for cracked, soiled caulking and damaged ceiling for recording in the maintenance log. 3c. The facility will continue with the weekly environmental QA rounds to detect and repair any damaged areas of the facility	

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			4. Deficient practices relating to shower rooms or any areas of the environment will be reported immediately to the Administrator for remedial action and discussed at Monthly Risk Management/ QA and Quarterly QA meetings.	12/18/08