STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INGLESIDE AT ROCK CREEK	**3050 MILITARY ROAD NW WASHINGTON, DC 20015**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** Based on record review and staff interview for 25 of 25 sampled residents, facility staff failed to develop person centered care plans with goals and objectives to address the residents at risk for developing COVID-19. Findings included . On June 9, 2020 at approximately 1:30 PM, a tour of the skilled nursing unit was conducted at the facility. There were no residents noted on isolation or quarantine related to the COVID-19 Virus. During a telephone interview with the facility on June 15, 2020 at approximately 2:15 PM Employees #1 and 2 acknowledged that there were no care plans to address the residents at risk for contracting COVID-19. They also stated, We have not had a positive case in house. We have tested all the residents and they are negative for COVID-19. The staff take the resident's vital signs every four (4) hours. All of the residents remain their rooms. The residents wear masks when they are in the room and when they come out of the room. We quarantine residents who are new admissions for 14 days. We check the temperature of all staff entering the building, and we have educated the staff on the use of Personal Protective Equipment and hand washing. Review of the person-centered care plans for 25 of 25 residents showed no evidence that the facility staff developed and implemented care plans with goals and interventions to address the care approaches for residents at risk for COVID-19.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.