FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com;

Visit http://www.jeffdowney.com

United Medical Nursing Home

1310 Southern Avenue NW
Washington DC 20032

Facility Characteristics:

- Skilled nursing facility with 120 beds that is embedded within the NFPHC
- Directed by Andrew Davis and Charletta Washington
- Website at www.united-medicalcenter.com

  The Not-for-Profit Hospital Corporation is a District of Columbia government hospital (not a private 501(c) entity) serving Southeast DC and surrounding Maryland communities
- As of 2018 United Medical Nursing Home was evaluated as a one-star facility (much below average) on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The District of Columbia Department of Health inspects nursing homes including UMNC. Periodically they do inspections as complain surveys which should be public record. You can write to Phillip Husband at Department of Health, 899 North Capitol Street, NE, Suite 247, Washington DC 20002 or email directly to Phillip.Husband@dc.gov. There is no initial fee for submitting a FOIA request. However, a public body may charge fees for searching, reviewing, and reproducing records as provided in 1 DCMR § 408. You may include in your request letter a specific statement limiting the amount of fees you are willing to pay. You may request a waiver or reduction of fees in your request letter. You must include a statement describing how the requested records will be used to benefit the general public. Pursuant to DC Official Code § 2-532(b), if the public body determines that a waiver or fee reduction is in the public interest, i.e., furnishing the records primarily benefits the general public, a waiver or reduction may be granted.

Having already researched United Medical Nursing Center and obtained FOIA responses, I am posting their statements of deficiencies here, in a searchable format. Keep in mind that these surveys may have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any questions about this or any other facility you may be interested in researching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the eFOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPIs. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

PRINTED:01/18/2018
FORM APPROVED

Health Reaulation & Ucens1 1nAdministration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERI SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLECONSTAUCTION A.' BUILDING : ------ B.WING	(X3) DATE SURVEY COMPLETED C 01/03/2018
	HFD02-0030		

NAME OF PROVIDER OR SUPPLIER: UNITED MEDICAL NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

()(4) 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 TOTHEAPPROPRIATE DEFICIENCY)	()(5) COMPLETE DATE
L000	**Initial Comments**	LOOO		

A complaint Investigation for C-18-008, DC-3461, was Initiated on October 26, 2017. The following deficiencies were based on observation, staff and resident interviews and record review. The sample size was 18 residents.

Abbreviations
AMS - Altered Mental Status
G-tube- Gastrostomy tube
EKG - 12lead Electrocardiogram
NP - Nurse Practltioner
BID - Twice- a-day
EMS- Emergency Medical Services (911)
HVAC - Heating Ventilation/Air conditioning
N euro - Neurological
8/P - Blood Pressure
CRF - Community Residential Facility
CNA- Certified NurseAide
DMH - Department of Mental Health
Peg tube - Percutaneous Endoscopic Gastrostomy
NP - Nurse Practitioner L- Liter
DI- Deciliter
CMS - Centers for Medicare and Medicaid Services

Lbs- Pounds (unit of mass) Medlcation
MAR- Admlnistration Record Medical Doctor
MD- Minimum Data Set
MDS- Milligrams (metric system unit of mass)
Mg- MIiiiiiters (metric system measure of mL- volume)

mg/di - Milligrams per Deciliter
m m/Hg - MIiiimeters of Mercury
POOT - Point of Contact
POS - Physician Order Sheet
Prn - As needed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Administrator. (X6)DATE: 1/23/2018

STATE FORM SUOR11 If continuation sheet 1 of 12

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L000	Continued From page 1	L000		
	Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission Screen and Resident Review ARD - Assessment Reference Date IDT- Interdisciplinary Team ID- Intellectual Disability QIS - Quality Indicator Survey O.C. - Districtof Columbia DIC- Discontinue Rp, RIP- Responsible Party PO-By Mouth			
L001	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 record review and staff interviews, it was determined that facility staff failed to maintain at least one (1) of three (3) glucometers to be immediately available for emergency use. The findings include: According to the facility's policy, • Accu-Chek Inform II Glucose Meter Test Procedure,° POCT 12.1, last reviewed June 28,2017, the following was noted on page 13 of 15: MQualltyControl (QC) Testing: The following will be performed on each new day of testing to confirm the test procedure performance before testing any patient specimen. a. The assigned normal and abnormal control	L001	1. An investigation was conducted. Two employees were disciplined as a result of investigation and according to policy. Resident #1 was transferred to the ED immediately where he was pronounced. 2. No other resident was found to have been affected by this deficient practice. The medical records of aU residents with a diabetes diagnosis and orders for blood sugar monitoring have been identified. All accu-check monitors were calibrated, serviced and supplies stocked 3. To prevent future occurrences and to ensure availability for emergency use, one Glucose Meter has been identified (labeled), on each unit and will be recalibrated at 1:00am daily. All licensed nursing staff will be re-educated on the "Accu-Check Inform II Glucose Meter Test Procedure", to include the Quality (QC) Testing calibration, to ensure compliance.	9/4/17 9/6/17 8/25/17 1n/18 1/7/18 1/16/18 Ongoing

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Loo1	Continued From page 2 solutions will be tested. b. The control solutions results must fall within their pre-established ranges before any patient testing can be performed. c. The QC reagents with other information must be recorded on the Glucose Meter Multi-Task QC Log that is stored In the department P0CT QC Notebook ..." On August 25, 2017 at approximately 4:45AM, Resident #2 requested assistance from Employee #4 to "change his roommate (Resident #1)." Facility staff attended to Resident #1, who required incontinent care. Resident #1 subsequently slid off the bed onto the floor and required four (4) staff members to place him/her back in bed. At that Ume, Resident #1 became unresponsive. Facility staff assessed the resident and Employee #4 took his/her blood sugar. CPR was Initiated and the resident was transferred to the emergency room, where he was pronounced at 6:01AM. According to Employee #4's written statement, "At about 4:42 AM on 8/25/17, the resident in room 7"" came to the nursing station and stated that • my roommate needs to be changed." I was the only one visible at the nursing station at the time because the other two charge nurses and the CNAs were at the back nursing station. I called the charge nurse who had that assignment Employee #5 and told him/her that his/her resident In room 7"" need to be changed. He/she now called the CNA and they both went to the resident At no point did the charge nurse or the CNA who went to the resident say that the resident was in distress other than resident needed to be changed ...Resident was assessed for Injuries, no apparent Injuries noted, was not in any acute distress, was lifted off the floor by four nurses back to his/her bed. I told the nurse that they need to get his/her vital signs while I went to	Loo1	The night shift nursing supervisor will be responsible for ensuring nightly calibration of glucometers on each unit. 4. Audits of Glucose Meter Daily Test logs will be conducted by the Unit Manager/designee daily and added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be provided to the DON who will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 1/16/18	Ongoing Ongoing

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L001	Continued From page 3 get the glucometer to do finger stick on the resident. I tried three different glucometers but was not able to use anyone of them because they have not been calibrated. I ended up calibrating one of the meters before I could check his/her sugar. The charge nurse and the CNA was with the resident at the time providing care to him/her and the resident was not In any acute distress ...• A telephone interview was conducted on October 27, 2017 at 9:40AM with Employee #4 regarding the use of the glucometers on August 25, 2017 at 1:00 PM. He/she stated, "The glucometers have to be calibrated after midnight every night. They won't work otherwise. It Is built Into the machine. They are usually calibrated right before the momlng blood sugars (6:00AM). That night I tried each of the glucometers and they had not been calibrated by the night shift yet. I calibrated one of the meters so I could use it to test Resident #1's blood sugar. He/she Is a diabetic. It took me two to three minutes, maybe less. The meters were not broken. They were just not calibrated." Facility staff failed to maintain at least one (1) of three (3) glucometers to be immediately available for emergency use. Employee 1#6 acknowledged the above In a telephone interview conducted on November 13, 2017. The record was reviewed October 26, 2017.	L001		
L051	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;	L051		

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(XI) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2J MULTIPLE CONSTRUCTION	(X31 DATE SURVEY COMPLETED
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1310 SOUTHERN AVENUE, SE, SUITE 200
WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
L051	Continued From page 4	L051		
	(b) Revlewlng medication records for completeness, accuracy In the transcription of physician orders, and adherences to stop order policies;		1. Resident #1 expired on 8/25/17. 2. All residents had the potential for being impacted by this deficient practice. As a result, Unit managers/designees are conducting hourly rounds for observation and monitoring of resident's condition	Ongoing
	(c) Revlewlng 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;		Respiratory assessment competencies are being completed for all licensed nursing staff to validate assessment and documentation skills.	Ongoing
	(e) Supervislng and evaluating each nursing employee on the unit; and			
	(f) Keeplng 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 a review of a surveillance video and audio tape, record review and staff interviews, in an Isolated incident for Resident #1, it was determined that facility staff failed to document an assessment of the resident's respiratory status after he/she complained that he/she could not breathe.		Unit Managers/Supervisors will review the 24 hour report daily to ensure appropriate assessment, treatment and documentation on residents with changes in respiratory status. Corrective action will be implemented as required.	Ongoing
	Thefindings include:		3. To prevent future occurrences, licensed staff were educated on respiratory assessments, treatments and documentation.	2/12/18 and ongoing
	Resident #1 was admitted to the facllity on July 27, 2017. According to the Minimum Data Set (MOS) assessment with an assessment reference date of August 3, 2017, Resident #1 scored 11/15 on the Brief Interview for Mental Status in Section C (Cognitive Patterns). According to the "MOS 3.0 User's Manual" page C-14, a score of "8-12" suggests that the resident has "moderately impaired" cognitive skills for daily decision making. Resident #1 was assessed as		Certified Nursing Assistants were educated on observation, change in condition and timely reporting to licensed staff.	1/12/18 and ongoing

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NAME OF PROVIDER OR SUPPLIER UNITED MEDICAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032		

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Los1	Continued From page 5 requiring limited assistance with eating, extensive assistance with bed mobility, transfers, dressing, toilet use and totally dependent for personal hygiene and bathing. Resident #1 was assessed with limited mobility of both upper and lower extremities on one side in Section G (Funetlonal Status). Disease diagnoses listed in Section I included: HIV+, Toxoplasmosis, Diabetes Mellltus, Cerebrovascular Accident with Hemiplegla/Hemiparesls, Hyponatremia, Cerebral Edema, Candldiasis, Thrombocytopenia, Malaise, Manic-Depression, and Vitamin D Deficiency. According to the surveillance audio and video tape reviewed on November 14,2017 and again on December 4, 2017 with enhanced audio, the following was noted: "4:50AM Resident #1 says "I can't breathe help me up.• Further conversation can be heard between Employee #5 and Resident #1 but not understandable." The following nurses' notes were reviewed: August24, 2017 at23:16 (11:16 PM): "Resident is alert and verbally responsive, no acute distress noted, routine meds was given and tolerated well. Finger stick was done, insulin coverage was given per sliding scale. Heparin therapy, no active bleeding noted, was provided with AOL care. Resident continue on rehab program for maximum bed mobility and total transfer continues." August 25, 2017 at 06:55 (6:55AM): "At 11 pm, writer went round to check on resident. Resident #1 was observed lying down on his/her bed alert and responsive. No complain of pain or respiratory distress voiced or observed. Bed was	LOS1	4. Audits ofthe monitoring of respiratory assessments and documentation will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be provided to the DON who will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 2/12/18	Ongoing

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STATEMENT OF DEFICIENCIES ANO PIAN OF CORRECTION	(X1) PROVIDEA/SUPPUERJCUA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X31 DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER
UNITED MEDICAL NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
1310SOUTHERN AVENUE, SE, SUITE 200
WASHINGTON, DC 20032

(X4} ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PAEAX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
L 051	Continued From page 6	I051		
	at lowest position and calf light was within reach. At 2:45 AM during the rounds, Resident #1 was observed watching TV. No complain voiced. At 5:10 AM Resident #1 call light came on and writer went to the room to answer the call light, resident's roommate was sitting on his wheelchair beside the resident's bed and writer observed the resident bed at high position. Resident stated "come and clean me up" his legs were hanging down by the bed side and writer quickly attempted to lower the bed down to prevent resident from falling from the bed •••" There was no evidence that facility staff assessed Resident #1 after he/she complained of not being able to breathe. Employee #2 acknowledged the above findings in a telephone interview on January 3, 2018 at 4:00 PM. The record was reviewed October 25, 2017.			
L206	3232.4 Nursing Faclltles Each incident shall be documented In the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff and resident interviews for one {1) of four (4) residents, for Resident #1, It was determined that facllity staff failed to accurately complete an incident report that was received by the Department of Health (DOH) on August 25, 2017 at 4:54pm and failed to inform DOH of a transfer of Resident #1 to the emergency room in a timely manner.	L206	1. Resident #1 expired on 8/25/17. The employee was re-educated on timely completion, DOH notification and submission of incident reports. 2. No other resident was impacted by this deficient practice. The medical records of all Emergency Department transfers from October to present were reviewed to ensure timely completion and reporting as required.	12/12/17 and ongoing

Health Reaulation & UcensmO Administration

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UNITED MEDICAL NURSING HOME	1310SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, CC 20032		

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L206	Continued From page 7 The findings include: 1. Facility staff failed to accurately complete an Incident reportthat was received by the Department of Health (DOH). An incident report was received by DOH on August 25, 2017 at 4:54PM as follows: "Datemme of Occurrence: 8125/17 5:10 AM EVENT OR INCIDENT DESCRIPTION Date: 8/25/17 Time: 5: 10 AM Location: Residenfs room Description: Resident was lower to the floor in sitting positon when observed sliding out of his/her bed. No Injury noted, ROM (Range of Motion) within nonnal 11ml Explain what immediate action was taken (include persons contacted) : Resident was assessed head to toe, no bruising, no injury noted, alert and oriented andverbally responsive, ROM within normal limit. Resident was assisted back to bed by staff. Medical Treatment necessary: No Licensee/Supervisor comments: Resident was encouraged to wait for staff before attempting to get out of bed by him/herself." According to the nurse's note dated August 25, 2017 at 6:55AM : "At 5:10AM Resldent#1 call light came on and writer went to the room to answer the call light, resident's roommate was sitting on his/her wheelchair beside the resident's bed and writer observed the resident bed at high position. Resident stated "come and clean me up" his/her legs were hanging down by the bed side and writer quickly attempted to lower the bed	L206	3. To prevent future occurrences, all licensed staff will be inserviced on the facility policies for accurate completion of incident reports and requirements/timeframes for DOH notification. All reportable facility incidents will be sent to the Administrator/designee (in his/her/absence) for review and reporting to the State Agency within the required regulatory timeframes. ED transfers has been added as a quality indicator for review/recording during Daily Stand-up meetings and reported to the CNO. An Acute Care Transfer Log and a "Quality Assessment and Performance Improvement Tool for Acute Care Transfer Reviews" form wiU be completed by the shift Supervisor or Unit Manager and the collected data will be monitored by the DON. Management Staff will be educated on use of the tools and expectations.	1/23/18 And ongoing Ongoing Ongoing

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L206	Continued From page 8 down to prevent resident from falling from the bed and his/her roommate started, "do not lower the bed, he/she want to be clean up right now.• Writer explained to the resident and his/her roommate that resident may fall out of bed if his/her bed remain up• The roommate get angry and stated cursing the writer. Writer lowered Resident#1 bed to prevent him/her from faffing but at this time resident get agitated, he/she trying to slide out of bed and writer eased him/her to the ground on sitting position before lay him/her down on the floor and call for help••. Resident was assessed on the floor and alert and responsive continue to request to be clean up. Resident was transferred back to bed. Writer assisted the CNA to clean resident, during cleaning observed the resident was getting disoriented. Care was stopped head on bed elevated 90 degrees called on resident's name but there was no respond, checked his/her vital sign P114, R 26, 8/P 90/47, and Temp 98.6. Oxygen 78% on room air. Noted that his/her pulse dropped to 58 then to no reading. CPR was initiated with 100% oxygen via non-rebreather. MD notified and order received to transfer him/her to ER. CPR continue until he/she got to ER. Resident *is* self RP but emergency contact was made aware.• A face⊕to-face Interview was conducted with Employee #1 on October 26, 2017 at 8:30AM. He/she was asked about the contents of the above cited incident report and stated, "I arrived to work about eight o"clock that morning, I didn't witness anything. I was filling In for Employee #2 who was off. I type the incident reports to be sent to DOH. I typed the incident report for Resident #1. Employee #1 was asked if he/she was aware at the time he/she prepared the incident report of	I206	4. ED transfers has been added as a clinical indicator on the QAPI management dashboard. A "Quality Assessment and Performance hnprovement Tool for Acute Care Transfer Reviews" will be used as a Quality Improvement Tool for review, analyzation and to identify opportunities for improvement. The DON will be responsible for monitoring Results of the monitoring will be submitted to the Assistant Administrator (who is responsible for Quality Assurance/Performance Improvement), for root cause analysis, trends, educational needs and care process improvement activities. Results of the review will be reported to the DON and Administrator and at the Quarterly Quality Assurance meeting by the Asst. Administrator. Unexpected deaths and ED transfers has been identified as an area for improvement and will be the focus for a Performance Improvement Project. 5. Corrective Action completion date: 2/12/18	12/28/17 and Ongoing

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UNITED MEDICAL NURSING HOME	1310SOUTHERNAVENUE, SE,SUITE200 WASHINGTON, DC 20032		

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L206	Continued From page 9 Resident #1's status (that Resident #1 expired in the emergency room at 6:01 AM the same morning). Employee #1 replied, "I heard he/she passed away in the ER that morning." Employee #1 was asked why he/she Included the last statement on the incident report "Resident was encouraged to wait for staff before attempting to get out of bed by him/herself." Employee #1 was shown a copy of the report and stated, "I don't know why I did that. The nurse who takes the patient downstairs (to the emergency room) fills out the transfer form (6-108). Ijust do the incidents and the social worker fills out the transfers that are not emergency. I don't know why I did that." Face-to-face interviews were conducted with the following residents on October 26, 2017 between 5:05AM and 8:30AM. The following residents were Identified from the DOH data base as having been transferred to the hospital. Resident #2 -sustained a fractured hip; severe osteoporosis and a pathological fracture per MD. Resident #3 - no Injury post fall - was transferred to the ER for a CT scan and returned the same day with no findings. Resident #4- arthritis flare up with swollen knee- went to the ER and returned same day with a brace. The residents were asked the circumstances of each incident that caused them to be transferred to the emergency room. No discrepancies were noted between the nurses' notes and the residents' explanation. The Transfer, Discharge, Relocation forms (6-108s) were reviewed and compared to the residents' record and corroborated by the residents. No discrepancies were noted.	I206		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIOERISUPPLIEAICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDINC3:-------- B.WING	(X31 DATE SURVEY COMPLETED C
	HFD02-0030		01/03/2018

NAME OF PROVIDER OR SUPPLIER: UNITED MEDICAL NURSING HOME

STREET ADOAESS, CITY, STATE, ZIP CODE: 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(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
L206	Continued From page 10	L2O6		
	A face-to-face interview was conducted with Employee #3 on October 26, 2017 at 2:00 PM. He/she was asked if he/she had reviewed the above incident report. Employee #3 stated, "I am the person who reviews all the Incident reports for completeness and correctness. That part about encouraging the resident to call for help is not right. It should have been amended. The whole incident would have been written up. This Incident report should have contained the facts that the resident became unresponsive, CPR was started and that the resident was sent to the ER.• The record was reviewed October 24, 2017.			
	2. In an isolated incident, facility stafffailed to inform the Department of Health (DOH) in a timely manner regarding the transfer of Resident #1 to the emergency room, who became unresponsive.			
	The findings include:			
	A Discharge, Relocation or Transfer was received on September 5, 2017 as follows by DOH: "Resident Name: Resident #1 The proposed action is: Transfer The specific reason for this action as follows: Resident was found unresponsive and transferred to the ER The following person from the facility is responsible for supervising the discharge, transfer or relocation: Employee #5 Date resident was transferred, discharged or relocated: August 25, 2017"			
	The transfer form was received by DOH 11 days after the transfer occurred.			
	According to the nurse's note dated August 25, 2017 at 6:55 AM : "At 5:10AM Resident #1 call			

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STATEME"'1" OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A.BUILDING=--------	(X3) DATE SURVEY COMPLETED
	HFD02-0030	B.WING	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XSJ COMPLETE DATE
L206	Continued From page 11	I.206		

light came on and writer went to the room to answer the call light, residents roommate was sitting on his/her wheelchair beside the resident's bed and writer observed the resident bed at high position. Resident stated "come and clean me up" his/her legs were hanging down by the bed side and writer quickly attempted to lower the bed down to prevent resident from falling from the bed and his/her roommate started, •do not lower the bed, he/she want to be clean up right now.• Writer explained to the resident and his/her roommate that resident may fall out of bed if his/her bed remain up• The roommate get angry and stated cursing the writer. Writer lowered Resident #1 bed to prevent him/her from falling but at this time resident get agitated, he/she trying to slide out of bed and writer eased him/her to the ground on sitting position before lay him/her down on the floor and call for help.•. Resident was assessed on the floor and alert and responsive continue to request to be clean up. Resident was transferred back to bed. Writer assisted the CNA to clean resident, during cleaning observed the resident was getting disoriented. Care was stopped head on bed elevated 90 degrees called on residents name but there was no respond, checked his/her vital sign P114, R26, B/P 90/47, and Temp 98.6. Oxygen 78% on room air. Noted that his/her pulse dropped to 58 then to no reading. CPR was initiated with 100% oxygen via non-rebreather. MO notified and order received to transfer him/her to ER. CPR continue until he/she got to ER. Resident is self RP but emergency contact was made aware.•

Employee #2 acknowledged the above findings in a telephone interview on January 3, 2018 at 4:00 PM. The record was reviewed October 25, 2017.

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	095039		C 12/01/2017
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
UNITED MEDICAL NURSING HOME		1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032	

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F 000	INITIAL COMMENTS	F000		

An unannounced complaint investigation for C-17-094, DC00003443 was conducted at United Medical Nursing Home from September 5, through December 1, 2017. The complaint survey activities consisted of a review of six (6) sampled residents.

The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The census during the survey was 113 residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations

AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice-a-day
B/P - Blood Pressure
CM - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA - Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR - District of Columbia Municipal Regulations
DIC - Discontinue
dl - deciliter
DMH - Department of Mental Health
ECG - Electrocardiogram
EMS - Emergency Medical Services (911)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Obeng — TITLE: Administrator — (X6) DATE: 1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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 dlsclosable 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 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		C 12/01/2017

NAME OF PROVIDER OR SUPPLIER
UNITED MEDICAL NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
1310 SOUTHERN AVENUE, SE, SUITE 200
WASHINGTON, DC 20032

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F000	Continued From page 1 G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air .conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set M milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/di - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party sec Special Care Center Sol- Solution TAR - Treatment Administration Record	F000		
F684 SS=G	Quality of Care CFR(s): 483.25	F684	An investigation was completed and the involved nurse was terminated.	8/30/17

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to

The record for resident #1 cannot be amended retrospectively. The resident exoired on Julv 26th, 2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 095039	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 12/01/2017
NAME OF PROVIDER OR SUPPLIER UNITED MEDICAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032	

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F 684	Continued From page 2 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with prof sional s ndards of practice, comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff intev iew, the facility failed to perform a respiratory assessment in conjunction with the administration of an "as needed" nebulizatior res iratory treatment and failed to assess resident for physiological and beh ral signs and symptoms of distress to facilitate prompt interventions to address changes in condition for Resident #1. Findings included ... Review of the facility's policy titled, "Cardio Pulmonary Resuscitation," dated 12/15/08 and revised 11/01/15, showed that the nurse would ssess chief complaint, duration physical ch nge, and will vital signs. Changes in the resident's vital signs frequently be monitored every "15-30 minutes." Resident #1's most recent admission on June 18, 2017, to the facility included diagnoses of Exacerbation of Chronic Obstructive Pulmonary Disease {COPD) and Right Lower Lobe Pneumonia, Review of the clinical record on September 5, 2017, showed that on July 14, 2017, Resident #1 began Methylpredisone taper {steroid used to treat inflammation) dose for the treatment of exacerbation of COPD. On July 21, 2017, the	F 684	2. No other resident was affected by this deficient practice. Medical records of all residents with the potential to be affected by the same deficient practice will be identified and reviewed to ensure receipt of treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices. 3. To prevent future occurrences and to ensure compliance, all licensed nursing staff will be re-educated on procedures and documentation for: Comprehensive respiratory assessments, assessment to determine resident state of unresponsiveness, changes in medical condition and medication administration policy for nebulizer treatments. 4. Monitoring of comprehensive respiratory assessments for residents that require, documentation for changes in condition and documentation for residents in receipt of nebulizer treatments will be added as nursing quality indicators to ensure compliance. Results of these audits will be reported monthly to the **DON**, who will provide the results to the Assistant Administrator.	1/20/18 2/1/18 2/9/18 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 3 physician ordered Azithromycin (antibiotic) 250 mg once daily for Bronchitis for four (4) days and Tessalon Perles capsules 100 milligrams three (3) times a day for a cough until August 10, 2017. Also, the physician ordered Albuterol nebulizer every six (6) hours as needed for wheezing related to shortness of breath on admission. Review of the nursing progress notes dated July 26, 2017, at 6:45 AM showed Resident #1 experienced a change in condition at "6:20 AM". The assessment was documented as: labored breathing and wheezing, vital signs: temperature-97.7 degree Fahrenheit, pulse-101 beat per minute, respirations- 22 breaths per minute, blood pressure- 158/73, peripheral capillary oxygen saturation-87%, blood sugar-137. Also, the resident was observed anxious, wheezing, sweating with [labored] breathing, and stating "I can't breathe." An order was received to transfer the resident to the Emergency Department for evaluation of respiratory distress. At 6:40 AM, Resident #1 was transferred to a stretcher and became "unresponsive." Consequently, the nursing staff initiated Cardiopulmonary Resuscitation (CPR). The clinical record does not reflect an assessment to depict Resident #1's state of unresponsiveness. Review of the electronic Medication Administration Record (eMAR) for July 2017 showed the facility staff administered Albuterol nebulization treatment for shortness of breath on July 26, 2017, at 6:30 **AM.** The clinical record lacked documentation of respiratory assessments associated with the administration of nebulization treatment to identify the needs of Resident #1. Review of the hospital Emergency Department	F 684	The DON will present the audit results at the quarterly Quality Assurance Committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 2/9/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 4	F 684		
	record showed that at 7:10 AM on July 26, 2017, Resident #1 was pronounced dead in the Emergency Department. The Emergency Department physician describes Resident #1 physical presentation to the Emergency Department as: cyanotic with signs of rigor mortis [the state of stiffening muscles after death with earliest onset in approximately 1-2 hours]. bilateral eye pupils fixed and dilated, with absent pulse and airway movement.			
	The clinical record lacked documented evidence of the observation and assessment to include the recording of physiological and behavioral signs and symptoms of distress when the resident's condition declined before transfer to the Emergency Department. The facility staff's failure to assess, evaluate interventions and promptly intervene placed Resident #1 at risk for harm.			
	During a face-to-face interview with Employee #1, Director of Executive Vice President/Chief Nursing Officer and Employee #2, Administrator on September 11, 2017, at approximately 10:15 AM, Employee #1 stated, "There is a discrepancy in the notes."		SS=D CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	
	Rigor Mortis Reference: Oberoi, S. S., Singh, P., Aggarwal, A. D., Walia, D. S., Bhullar, D. S., & Aggarwal, K. K. (2015), Factors affecting estimation of time since death by rigor mortis. Journal Of Punjab Academy Of Forensic Medicine & Toxicology, 15(2), 81-85.			
F 842	Resident Records - Identifiable Information	F 842		

1. The record for Resident #1 cannot be amended retrospectively. The resident exoired on Julv26. 2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ 8. WING ____	(X3) DATE SURVEY COMPLETED
	095039		C 12/01/2017

NAME DF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
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F 842	Continued From page 5 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent omy in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.?0(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; ***(iv)*** For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	2. No other resident was harmed by this deficient practice. Medical records for all residents with diagnosis of COPD were audited to ensure that nursing interventions have been initiated and that appropriate treatment and services to restore or improve normal respiratory function have been implemented. 3. To prevent future occurrences and to ensure compliance, all licensed nursing staff will be re-educated on the facility Cardio-Pulmonary Resuscitation policy, procedures and documentation for: comprehensive assessments, changes in medical condition, as it relates to the individual residents' comprehensive person-centered care plan, residents' choices and in accordance with professional standards of practice. Nursing management will review the 24 hour report daily to ensure appropriate assessment and treatment of residents identified with respiratory distress. The nursing management team will implement immediate corrective action per findings on rounds and review of the 24 hour report. Findings will be reported to the DON	12/23/17 2/9/18 and on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 8. WING	{)(3) DATE SURVEY COMPLETED
	095039		C 12/01/2017

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F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i){3) The f ility must s afeguard medical record inform ation against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Fiv years from the date of discharge when there is no requirement in State law; or {iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70{i)(5) The medical record must contain- {i) Suf icient information to identify the resident; i) A r ord of th resident's assessment (iii) The comprehensive plan of care and services provid ; (iv) The results of any preadmission screening and resi n review evaluations and determinations conducted by the State; (v) Physici 's, nurse's, and other licensed professional's progress notes; and (vi) Labo tory, r diology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Basedon facility cor spondence, record review and staf interview, for one (1) of six (6) sampled residents; the facility staff f iled to accurat ly assess Resident #1's clinical condition when the resident became unresponsive. ; Findings included: Resident #1's most recent admissi n on June 18, 2017, to the facility included diagnoses of Exacerbation of Chronic Obstructive Pulmonary	F 842	3. (Cont'd) All new admissions and re-admissions with COPD will be reviewed to ensure a comprehensive respiratory assessment is developed and implemented to ensure appropriate nursing intervention, treatment and services. Findings from hospital records will be discussed to increase staff knowledge and understanding of findings from various diagnostic studies used in the management of COPD 4. Monitoring resident comprehensive assessmen , resident care plans to e sure that they are person-centered and resident choices will be added as nursing quality indicators to ensure compliance until three months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator by the DON who will also report at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficien es. 5. Corrective action completion date: 2/9/18	Ongoing Ongoing Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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				Ongoing
F 842	Continued From page 7 Disease (COPD) and Right Lower Lobe Pneumonia. Review of the clinical record on September 5, 2017, showed that on July 14, 2017, Resident #1 began Methylpredisone taper (steroid used to treat inflammation) dose for the treatment of exacerbation of COPD. On July 21, 2017, the physician ordered Azithromycin (antibiotic) 250 mg once daily for Bronchitis for four (4) days and Tessalon Perlas capsules 100 milligrams three (3) times a day for a cough until August 10, 2017. Review of the nursing progress notes dated July 26, 2017, at 6:45 AM showed Resident #1 experienced a change in condition at "6:20 AM". The nursing staff documented the assessments: labored breathing and wheezing, vital sign►: temperature-97.7 degree Fahrenheit, pulse- 101 beat per minute, respirations- 22· breaths per minute, blood pressure- 158/73, peripheral capillary oxygen saturation- 87%, blood sugar- 137. Also, the resident was observed anxious, wheezing, sweating with labored breathing, and stating "I can't breathe." An order was received to transfer the resident to the Emergency Department for evaluation of respiratory distress. At 6:40 AM, Resident #1 was transferred to a stretcher and became "unresponsive." Consequently, the nursing staff initiated Cardiopulmonary Resuscitation (CPR). Review of the electronic Medication Administration Record (eMAR) for July 2017 showed the facility staff administered Albuterol nebulization treatment for shortness of breath on July 26, 20i7, at 6:30 AM. The clinical record lacked documentation of respiratory assessments associated with the administration of nebulization	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		C 12/01/2017

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F842	Continued From page 8 treatment. Review of the facility's policy titled, "Cardio Pulmonary Resuscitation," dated 12/15/08 and revised 11/01/15, showed that the nurse would assess chief complaint, duration physical change, and vital signs. Changes in the resident's vital signs will frequently be monitored every "15-30 minutes." The clinical record lacked documented evidence of the observation and assessment to include the recording of physiological and behavioral signs and symptoms of distress when the resident's condition declined before transfer to the Emergency Department. In addition, the clinical record lacked documentation of times of corresponding care and treatment delivery to include the time of transfer to Emergency Department, Code Blue activation, and Rapid Response team response.times. In addition, the clinical record does not contain documentation to support frequent monitoring in accordance with the facility's policy. The findings reviewed with Employee #1, Director of Executive Vice President/Chief Nursing Officer, acknowledged the findings.	F 842		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER R MEDICARE MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 7W • UNITED MEDICAL NURSING CENTER B. WING	(X3) DATE SURVEY COMPLETED
	095039		11 302017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY.STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE,SUITE200 WASHINGTON, DC 20032

(X4) D 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 [)I>,TE
K 000	INITIAL COMMENTS The following findings were observed during the Life Safety Code Inspection on November 30, 2017.	K000	1. The tamper and flow switches and supervisory signal devices were tested.	12/22/17
K 353 SS=D	Sprinkler System• Maintenance and Testing CFR(s): NFPA 101 Sprinkler System- Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1. Based on observations, interview and a review of documents, during the Life Safety Code Inspection, the facility failed to ensure the tamper flow and supervisory signal devices were tested quarterly as required, in one (1) of two (2) observations. Findings included... During a record review of the Sprinkler Records	K353	2. All facility water flow alarm devices (tamper and flow switches and supervisory signal devices) were inspected by the environmental team. All deficient areas were corrected. 3. To prevent future occurrences, staff will be in-serviced on inspection of water flow alarm devices to ensure compliance. 4. Tamper flow and supervisory signal device inspections will be added as quality indicators to the environmental roundrg tool for quarterly inspections. Results of the inspections will be presented to the quarterly Quality Assurance Committee meeting by the Director of Facilities Management. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date:	12/22/17 12/29/17 and ongoing 1/1/18 and Ongoing 1/1/18 and ongoing

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

Stephen G — Administrator — 12/29/17

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 DEFCIENCIES AND PLAN OF CORRECTION	(X1) PROVDER/SUPPLIER/CLIA IDENTIFCATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING ?W- UNITED MEDICAL NURSING CENTER B.WNG	11L30/2017

NAME OF PROVIDER OR SUPPLIER: UNITED MEDICAL NURSING HOME

STREET ADDRESS, CITY.STATE, ZIP CODE: 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR 11\TE DEFICIENCY)	(XS) COMPLETION DATE
K353	Continued From page 1 3 on November 30, 2017; the record showed the water flow alarm devices to include the tamper and flow switches, and supervisory signal devices were not tested on a quarterly basis as required. The sprinkler, tamper and flow switches and supervisor signal devices were not tested during the third quarter (July, August, and September) of 2017, in one (1) of two (2) observations at 3:50 PM on November 29, 2017. Reference NFPA 25-5.2.5. 2. Based on observations during the Life Safety Code Inspection, the facility failed to ensure the sprinklers were maintained in a manner to ensure the proper sprinkler operation, as evidenced by soiled sprinklers and escutcheon rings, paint on escutcheon rings, and sprinkler heads in nine (9) of 46 observations. Findings included... 1. Sprinklers and escutcheon rings soiled with dust, and rust accumulation on the head surfaces of sprinklers and cylindrical surfaces of escutcheon rings, in Rooms 604, 661, 637, 744, 759 in five (5) of 23 observations between 4:15PM and 6:05PM on November 30, 2017. 2. Paint on sprinkler heads and escutcheon rings in Rooms 637, 644, Seventh Floor Laundry Room and Room 652 Bathing Room, in four (4) of 23 observations between 4:15 PM at 6:05 PM on November 30, 2017. The observations made, in the presence of Maintenance Director and Assistant Director, were acknowledged.	K35	1. Paint was removed from observed 7 sprinkler heads and escutcheon rings Soiled sprinkler heads and escutcheon rings were cleaned. 2 . All facility sprinkler heads and escutcheon rings were checked to ensure proper operation. 3. To prevent future occurrences and to ensure compliance,the Director of Building Services re-educated painters regarding the potential hazard of paint on sprinkler heads and escutcheon rings . Inspection s will also be conducted after painting in the a rea of sprinkler heads to ensure proper clean up. 4. Inspection of sprinkler heads and escutcheon rings will be added as a quality indicator to the environmental rounds audit tool to ensure compliance. Results of the audits will be submitted to the Assistant Administrator on a monthly basis by the Director of Facilities Management who will also report at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. **Ongoing** 5.Corrective completion date: 12/29/17	'J2/22/1 12/22/17 12/22/17 12/15/17 of Ongoing

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CU A IDENTIFICATION NUMBER	(X2) MULTIPL CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING 7W • UNITED MEDICAL NURSING CENTER SWING	11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(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)	(XS) COMPLETION DATE
K 362	Continued From page 2	K362	1. The sixth floor conduit pipes were repaired to prevent passage of smoke between floors---	12/22/17
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. Infully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. IT me wa1ls nave a nre resistance rating, give me rating if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations during the Life Safety Code Inspection, the facility failed to ensure the ceiling surfaces were free from penetrations, in the Electrical Room, to prevent the passage of smoke in the event of an emergency, in three (3) of three observations. Findings included ... During tour on November 30, 2017 at approximately 4:30 PM, the following observations were made:	K362	The two one inch pipes penetrating wall surfaces were closed on the ends. The two- inch opening around a five inch pipe passing through the floor surfaces was closed. 2' All Facility ceiling surfaces were inspected to ensure that they were free from penetrations. Any deficient area found was corrected. 3. To prevent future occurrences and to ensure compliance, ceiling surfaces will be monitored during environmental rounds to ensure that they are free from penetrations and to ensure compliance. 4. Monitoring of ceiling surfaces will beaddedasa Facilities Management quality indicator to ensure compliance.	12/22/17 12/22/17 12/22/17 12/22/17-ongoing Ongoing

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION	(X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING 7W - UNITED MEDICAL NURSING CENTER B WING	(X3) DATE SURVEY COMPLETED
	095039		11/30/2017

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K362	Continued From page 3 A. Conduit pipes, in the Sixth Floor Electric Room, not capped or covered to prevent the passage of smoke between floors B. Two (2), one inch pipes penetrating wall surfaces were open on the ends C. A two-inch opening around a five inch pipe passing through floor surfaces The observations made, in the presence of Maintenance Director and Assistant Director, were acknowledged.	K362	**4(cont'd).** Results of the findings will be documented bythe Director of Facilities Management/designee and reported by the Director at the quarterly Quality Assurance Committee Meeting. The QACwill ensure oversight and correction of anyidentified Deficiencies. 5. Corrective action compliance date: 12/29/17	Ongoing
K363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors 2012 EXIST ING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are	K363	1. Props were removed from entrance doors to **Rooms 728** and **745.** • Entrance door to resident **Room 728** has been repaired. • Entrance door to resident **Room 745** has been repaired. • The entrance door to **Room 618** has been repaired. 2. All doors protecting corridor openings were inspected to ensure there was no impediment to closing and that they were provided with a means suitable for keeping the doors closed to ensure compliance.	12/22/17 12/22/17 12/22/17 12/22/17 12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 7W -UNITED MEDICAL NURSING CENTER 8. WING	(X3) DATE SURVEY COMPLETED
	095039		11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDR ESS, CITY, STATEZIP CODE
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K 363	Continued From page 4 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3,42 CFR Parts 403, 418, 460 ,482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations during the Ute Safety Code Inspection, the facility failed to ensure that one (1) door in common areas closed when tested. In addition, one (1) door was propped open with door stops, prevented the door from closing, and prevent the passage of smoke in the event of a fire. Findings included... During a tour of the facility on November 30, 2017, the following observations were made: A. The door at the entrance to Room 618 failed to close and latch into the frame, when tested in one (1) of 15observations B. The door at the entrance to Room 728 was improperly held in the open position with a wedge and a chair was used to hold a door open at the entrance to Room 745 (Day Room).The use of the wedge and chair prevented the doors from closing creating a potential fire hazard in the event of an emergency, in the event of an	K363	3. To prevent future occurrences and to ensure compliance, staff education will be conducted on inspection and repair of doors that protect corridor to ensure resident safety. 4. Inspection of doors that protect corridor openings will be added as a Facilities Management quality indicator. Results of the audits will be reported the Assistant Administrator monthly and presented at the quarterly Quality Assurance committee meeting by the Director of Facilities Management. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: **1/12/18**	1/12/18 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A BUILDING 7W - UNITED MEDICAL NURSING CENTER SWING	11/30/2017

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	K 363 Continued From page 5 emergency, in two (2) of 20 observations between 5:00PM and 5:35PM November 30,2017. The observations made, in the presence of Maintenance Director and Assistant Director, were acknowledged.	K363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at United Medical Nursing Home from November 6, 2017 through November 14, 2017. Survey activities consisted of a review of 30 residents' clinical records during Stage 1: and review of 39 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The census during the survey was 115 residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services **CNA-** Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations *DIC* Discontinue DI - deciliter	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Abenle
TITLE: Administrator
(X6) DATE: 1/17/2018

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.

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F 000	Continued From page 1 DMH Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC - Health Service Center HVAC Heating ventilation/Air conditioning ID - Intellectual disability IDT- interdisciplinary team L- Liter Lbs - Pounds (unit of mass) MAR- Medication Administration Record MD- Medical Doctor MDS- Minimum Data Set Mg- milligrams (metric system unit of mass) ml- milliliters (metric system measure of volume) mg/di - milligrams per deciliter mm/Hg- millimeters of mercury MN midnight Neuro - Neurological NP Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS- physician's order sheet Pm- As needed Pt- Patient Q- Every QIS- Quality Indicator Survey Rp, RIP- Responsible party SeC Special Care Center Sol- Solution TAR- Treatment Administration Record	F 000		
F 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g){1)(4)(5)(13)(16)-(18)	F 156		

STATEMENT OF DEFICIENCIES ANO PLAN OF COR RECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B.WING	(X3) DATE SURVEY COMPLETED
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F 156	**Continued From page 2** **(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.** **§483.10(9) Information and Communication.** **(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.** **(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing {including Braille) in a format and a language he or she understands, including:** **(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -** **{A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;** **(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.** **(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective**	F 156	1. **Resident# 52** rights were reviewed immediately by social worker/Activities director with resident. 2. No other resident was affected by this deficiency evidenced by review of resident's right with all residents on admission. Employee# 8 was counseled on reviewing of resident's right on admission, quarterly care plan meetings, and family/resident's council meetings. The SW. admissions and Recreation Therapy staff will also review residents' rights **3.** To prevent future occurrences, the Admissions Coordinator, Social Workers and Director of Recreation Therapy will be re-educated on residents' rights. The Director of Recreational Services **will** have Residents Rights on the agenda **for discussion at each Resident** Council **meeting.**	11/13/17 11/13/17 **12/29/17** and **ongoing**

D PARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017
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F 156	Continued From page 3	F 156	4. Residents Rights review audits will be added as a Social Wo Depat ment quality indicator to ensure compliance until three months of gr ter than or equal to 95% compliance is achieved. The results of the quarterly audits will be provided to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	Ongoing
	services where state law provides for jurisdiction in long-term care facilities, the local contact agency for in t nin format n about re ur g to the community and the Medicaid Fraud Control Unit; and (D) A sta men that th resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, negl t, ploitation, misappropriation of resident propety in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.		5. Correction Completion date: 12/29/17	
	(ii) Information and contact informat on for State and local advocacy organizations including but not limited to the State Survey Agency, the Sta e Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advoc cy stem (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2))			
	(ii Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]			
	(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(8)(iii) of the Older Americans			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

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F 156	Continued From page 4 Act); or other No Wrong Door Program; [§483.10(g}(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)) (v) Contact information for the Medicaid Fraud Control Unit; and (§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)1 (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g){5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING ____ B.WING ____	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 5 limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2)MULTIPLE CONSTRUCTION A BUILDING ____ B WING ____	(X3)DATE SURVEY COMPLETED
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F 156	Continued From page 6 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (8) Those other items and services that the facility offers and for which the resident may be charged and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 156		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER·	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4)1D 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)	(X5J COMPLETION DATE
F156	Continued From page 7 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview for one (1) of 39 Stage 2 sampled residents, the facility staff failed to discuss and review the rights of residents throughout their stay in the facility. Resident **#52.** Findings included.... During an interview on November 11, 2017, at approximately 11:00 AM, Resident#52 stated "the staff does not talk about or review our rights unless there is a problem, they just don't tell of us our rights as residents." On November 13, 2017, at approximately 1:00 PM, a face-to-face meeting with Employee# 8 stated, 'We don't usually discuss resident rights unless there is a concern, then it is addressed, we don't just review their rights." Employee#18 acknowledged the findings at the	F 156		

STATEMENT OFDEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	095039	8. WING	11/14/2017
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE. ZIP CODE	
UNITED MEDICAL NURSING HOME		1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032	

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F 156	Continued From page 8 time of the interview.	F 156		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(9)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident: consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences. or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F157	1. **Resident# 24** responsible party was notified on November 9th **2017.** The Clinical Manager of the unit was counseled for the absence of documentation in the resident's medical record and failure to notify the RP when an allegation of abuse was reported while receiving care from the nursing staff. 2. No other resident was affected by this deficient practice as evidenced by results of the audits of Medical records of all residents with allegations of abuse and grievances. Review of any alleged abuse/grievances will be done by the Director of nursing to ensure compliance with notification of the resident's responsible party. 3. To prevent future occurrences all staff will be re-educated on the facility policy for notification of the RP when there is an allegation of abuse/grievance.	11/9/17 11/9/17 12/29/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	{X2)MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3)DATE SURVEY COMPLETED
	096039		11/14/2017

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F 157	Continued From page 9 Resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e}(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e}(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview for one (1) of 39 sampled residents, the facility failed to notify the resident's Responsible Party (RP) of an allegation of abuse experienced while receiving care from the nursing staff. Resident #24. Findings included ... Resident #24 last admitted to the facility on July 26, 2013, with diagnoses which included Non-Alzheimer's Dementia, Hypertension, Age-related Debility, Cerebrovascular Accident, Seizures and Thyroid Disorder. While conducting a Stage 1 resident interview on November 7, 2017, at approximately 3:00 PM, the surveyor asked; has anyone ever abused you in any way? He responded, "Yes." The resident further stated that "the nurse hit me; it was a long time ago." The roommate interjected and stated, "It was two months ago." The surveyor interviewed Resident #24 roommate about the alleged incident. "I was lying	F 1571	Notification of RP will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results will be reported to the Quarterly Quality Assurance Committee meeting by the DON. 5 Correction completion date 12/29/17	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 10 right here in this bed, and I heard him [Resident #24) say, you hit me. Don't hit me" The roommate stated that he reported the incident to the nurse the next day. During a face-to-face interview with Employee #6 at appropriately 3:00 PM on November 7, 2017, Employee #6 initially she acknowledged receiving a report which she interpreted as a complaint and not as an allegation of abuse. According, to Employee #6, the incident occurred sometime during the night shift on September 12, 2017. Resident #24 clinical record lacked documented evidence of the responsible party notification. During the second interview with Employee #6 on November 7, 2017, at approximately 4:00 PM, she acknowledged the failure to notify Resident #24 responsible party of the allegation of abuse.	F 157		
F 167 SS"'C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE **CFR(s):** 483.10(g)(10)(i)(11) (g)(1O) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility: and (g){11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONSTRUCTION A.BUILDING _____ 8.WING _____	(X3) DATE SURVEY COMPLETED
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F 167	**Continued From page 11** certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to make available for examination the most recent survey results. The census in the facility on the first day of the survey was 115 residents. Findings included... On November 6, 2017, at approximately 1:30 PM, the State Agency, Representative observed binders located on the 6th and 7th floor next to the elevators. The binders on each floor contained "The Statement of Deficiencies" dated November 9, 2015, which did not reflect the most recent annual recertification survey results completed on December 5, 2016. There was no evidence that the facility staff made available for examination, the most recent survey results for residents and visitors review. Employee #2 acknowledged the findings during a face-to-face interview on November 6, 2017, at	F 167	1. The location of the survey report was posted on the 6th and 7th floor by the elevator In front of the nursing station immediately upon discovery. 2. Revised and typed survey report were permanently posted on the 6th and 7th floor by the elevator in front of the nursing station. 3. To prevent future occurrences staff and residents were reminded of the location of the survey results during quarterly care plan meetings, and will be included in the agenda for family/resident's council meeting. Resident's families and the Resident will be Informed of the location of the postings during residents/Family councils meeting. 4. Verification of location of the required postings will be added as a quality indicator on the environment of care rounds and nursing for review during dally stand-up meetings to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the DON and presented at the quarterly Quality Assurance Committee meeting. The QAC will ensure oversight and correction of any Identified deficiency. S. Correction Completion date: 12/29/17	11/6/17 11/6/17 12/21/17 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 167	Continued From page 12 approximately 3:30 PM.	F 167	5.	
F 168 SS=C	RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES CFR(s): 483.10(g)(10)(ii)(k) (g)(10) The resident has the right to- (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. (k) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally !II Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide residents and visitors the current contact information for the State Agency to facilitate the opportunity for communication. The census in the facility on the first day of the survey was 115 residents.	F 168	1. This deficiency was corrected immediately. Contact information for the State Agency, to facilitate the opportunity for and visitors was updated and placed in hallway showcases on the 6th and 7th floors. 2. No other resident was affected by this deficient practice. Revised and typed postings were permanently posted in the hallways on the 6th and 7th floor. 3. To prevent future occurrences residents and visitors were reminded of the location and update of the State Agency by the Social Work and Recreation Departments during the family/resident's council meeting. 4. Verification of location of the required postings will be added as a quality indicator on	11/6/17 11/6/17 12/21/17 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F168	Continued From page 13 Findings included... On November 6, 2017, at approximately 1:30 PM, signage related to contact information for agencies acting as client advocates was posted on the wall, in the hallway of the facility. The signage posted did not show the correct name of the Program Manager for the Department of Health, Health Care Facilities Division. There was no evidence that the facility staff provided residents and visitors the current contact information for the State Agency. Employee #2 acknowledged the findings during a face-to-face interview on November 6, 2017, at approximately 3.30 PM.	F168	(#4 Cont'd) the environment of care rounds and as a nursing quality indicator for review during the daily stand-up meetings to ensure compliance until three consecutive months of greater than or equal to **95%** compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the Social Work and Recreation Departments and presented at the quarterly Quality Assurance Committee meeting. The QAC w ill ensure oversight and correction of any identified deficiency. **5.** Corrective Action Completion date: **12/29/17**	**Ongoing**
F 170 SS:::D	RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL CFR(s): 483.10(g)(8)(i)(9)(i)-(iii)(h)(2) (9)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.	F170		

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F 170	Continued From page 14 {iii) Such use must comply with State and Federal law. {h){2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral {that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This R EQUIREMENT is not met as evidenced by: Based on a resident and staff interviews for one (1) of 39 Stage 2 sampled residents, the facility staff failed to deliver mail to residents when there is regularly scheduled postal delivery to the facility. {Resident #52) Findings included... During an interview on November 11, 2017, at, approximately 11:00 AM, Resident #52 stated, 'We don't get mail on Saturdays. I know that I don't get mail and there are a couple of other residents that I know of that don't get mail either." On November 13, 2017, at approximately 1:OO PM, during a face-to-face interview with Employee# 18 stated, "This has been an ongoing problem at the facility. If my assistants are not here, the residents do not get their mail. Yes, my staff work on Saturdays but if they do not come to the floor, no one wants to accept responsibility for the resident's mail, so the residents get their mail delivered on Monday, and currently there is no process in place."	F 170	1. Saturday mail delivery resumed on November 18th The Director of Therapeutic Recreation was reeducated on the regulatory requirement and facility responsibility for delivery of mail to residents. 2. Mail is being delivered to residents in a timely manner by the staff of the recreation department (Monday-Saturday). Recreation aides assigned to weekday and weekend coverage will deliver resident's mail within 24hrs of receipt by the facility. The Director of Recreation **will** ensure mail delivery. 3. To prevent future occurrences, recreation department staff was re-educated regarding the regulatory requirement for delivery of mall to residents to ensure compliance. The Director of Therapeutic Recreation/designee will monitor mail delivery to ensure compliance. 4. Resident mail delivery **will** be added as a recreation therapy quality indicator to ensure compliance.	11/18/17 11/9/17 Ongoing Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 170	C ontinued From page 15 Employee#18 acknowledged the findings at the time of the interview.	F 170	The Director of Therapeutic Recreation will present the results of the monitoring monthly to the Assistant Administrator until three consecutive months of greater than or equal to 95% compliance is achieved and to the quarterly Q uality Assurance committee. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: *12/29/17*	Ongoing
F225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS C FR(s}: 483.12(a)(3}(4)(c}(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i} Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii} Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) R eport to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c} In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1} Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F225		

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F 225	Continued From page 16 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not tater than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 Stage 2 sampled residents, facility staff failed to report an alleged abuse to the State Agency. Resident #24. Findings include ...	F 225	1. ***Resident #24*** incident of alleged abused was reported to the state agency on November 9th 2017 The clinical manager of the unit was counseled after the surveyor visit regarding the Identified absence of staff's failure to report the alleged abuse to the state agency 2. No other resident was affected by this deficient practice as evidenced by audit results of all Medical records of residents with allegations of abuse to ensure that it was reported to the state agency. 3. To prevent future occurrences, all staff, including nursing leadership, licensed nurses, CNAs, Social Work and Recreation Therapy, was re-educated, on the facility policy for notification of the state agency when there is an allegation of abuse to ensure compliance. 4. Abuse allegations/investigation will be added as a nursing quality indicator to ensure compliance. Compliance monitoring will be done by the D0N/designee. Results of the audits will be reported to the Assistant Administrator monthly and presented at the quarterly Quality Assurance committee meeting.	11/9/17 11/12/17 12/5/17 and ongoing Ongoing

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F 225	Continued From page 17 22 District of Columbia Municipal Regulations 3232.4 stipulates, "Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." During a Stage 1 Resident interview at approximately 3:00 PM on November 7, 2017, Resident #24 informed this writer that a CNA hit him on his arm while providing his care. The resident was unable to confirm the date or time of the incident. However, the resident's roommate (Resident #127) stated the alleged incident occurred approximately two (2) months ago. A review of the "Resident Concern/Complaint Form" dated September 12, 2017 revealed "The nurse reported to this worker (social worker, Employee #10) that a certified nurse aide (CNA) had hit his roommate last night." During a face-to-face interview with Employee **#6,** 7th floor Unit Manager at approximately 5:30 PM on November 7, 2017, Employee **#6** stated she was aware that a resident alleged he was hit by a CNA. The employee responded, "A few months ago the Social Worker investigated a concern from the resident." During a face-to-face interview with Employee #11 at approximately 5:40 PM on November 7, 2017, Employee #11 stated she received the	F 225	The **QAC** will ensure oversight and correction of any Identified deficiencies. Corrective action completion date: 12/29/17.	**Ongoing**

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F225	Continued From page 18 complaint from the resident's roommate and forwarded it to the Social Worker and her Supervisor. She stated Resident #24 did not identify the location where he was hit. The employee admits that she did not assess the resident's body for injuries and made no documentation in the resident's clinical record. Her responsibility as she understood it was to collect the information about the complaint and pass it on to her supervisor. She did not initiate an incident report or call the Responsible Party to report the allegation. During a subsequent face-to-face interview with Employee #2 at approximately November 7,2017 at 6:02 PM, the Employee acknowledged reporting the incident as a complaint. The employee stated they interviewed Resident #24 and asked if he remembered somebody hitting him. The resident was unable to tell what day it happened. He said the person tapped him because he was not doing what she asked. Also, Employee #2 stated the facility did not notify the State Agency. Facility staff failed to report an allegation of abuse of a resident by the facility staff to the State Agency. Employee #2 acknowledged the finding.	F225		
F226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC P OLICIES CFR(s):483.12 (b)(1)-(3).483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1} Prohibit and prevent abuse, neglect, and	F226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B.WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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WASHINGTON, DC 20032

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F226	Continued From page 19 exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, **483.95** (c} Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1} Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3} Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and *staff* interview for one (1) of 39 Stage 2 sampled residents, facility staff failed to report an alleged abuse to the State Agency in accordance with the facility policy for one (1} Resident #24. Findings include ... Facility Policy: "Resident abuse, neglect,	F226	1. **Resident # 24-** RP was notified on November 9th 2017. The Clinical Manager of the unit was counseled for the absence of documentation in **Resident# 24's** medical record and failure to notify the RP when an allegation of abuse was reported while receiving care from the nursing staff. 2. No other resident was affected by this deficient practice as evidenced by audits of all Medical records of residents with allegations of abuse to ensure compliance. 3. To prevent future occurrences, In-service training will be provided to all staff regarding the facility policy on notifying the RP when there is an allegation of abuse identified. 4. Notification of RP will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results will be reported to the Quarterly Quality Assurance Committee meeting by the DON. **5.** Completion date: 12/29/17	11/9/17 11/9/17 **Ongoing** **Ongoing**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	) Continued From page 20 exploitation and misappropriation of property" Policy Number SNS 51, effective updated 11/5/15 stipulates: "All incidents of possible abuse, neglect, or mistreatment, including injuries that suggest abuse, neglect, or mistreatment resident, will be reported as soon as reasonably practicable, to the administrator, director of nursing or their designees. An "Occurrence Report" will be completed consistent with the policies and procedures to occurrence reports. The administrator and Director of Nursing will determine whether the information contained in the Occurrence Report warrants suspicion of abuse and if so require notification and investigation of the incident consistent with Corporate Policy and Procedure, regulatory Agencies and with applicable legal obligations. Reporting Suspected Abuse: If the Administrator or Director of Nursing determine that abuse is suspected, their designee must Immediately report the case of suspected abuse to the appropriate jurisdictional authorities: License Regulatory Agency, Ombudsman Office. Treating Suspected Abuse: Residents who are the suspected object of abuse, neglect or mistreatment should: Be physically examined immediately by a Registered Nurse to determine whether the resident has suffered symptoms of physical harm."	F226		

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F 226	Continued From page 21 During a Stage 1 Resident interview at approximately 3:00 PM on November 7, 2017, Resident #24 informed this writer that a CNA hit him on his arm while providing his care. The resident was unable to confirm the date or time of the incident. However, the resident's roommate (Resident #127) stated the alleged incident occurred approximately two (2) months ago. A review of the "Resident Concern/Complaint Form" dated September 12, 2017 revealed "The nurse reported to this worker (social worker, Employee #10) that a certified nurse aide (CNA) had hit his roommate last night." A face-to-face interview was conducted with Employee #6, 7th floor Unit Manager at approximately 5:30 PM on November 7, 2017. Employee #6 was asked whether she was aware that a resident alleged he was hit by a CNA. The employee responded, "A few months ago the Social Worker investigated a concern from the resident." A face-to-face interview was conducted with Employee #11 (the nurse assigned to the resident) at approximately 5:40 PM on November 7, 2017. Employee #11 stated she received the complaint from the resident's roommate (Resident #127) and forwarded it to the Social Worker and her Supervisor. She stated (Resident #24] did not show her where he was hit. The employee admits that she did not assess the resident's body for injuries and made no documentation in the resident's record. Her responsibility as she understood it was to collect the information about the complaint and pass it on to her supervisor.	F 226		

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F 226	Continued From page 22 She did not initiate an incident report or call the RP to report the allegation. A face-to-face interview was conducted with Employee #2 at approximately 6:02 PM on November 7, 2017. The employee acknowledged that the report was initiated as a complaint. The employee stated they interviewed [Resident #241 and asked if he remembered somebody hitting him. The resident was unable to tell what day it happened. He (Resident #24) said the person tapped him because he was not doing what she (Employee #12) asked. Employee #2 was asked whether the allegation that a CNA hit Resident #24 was ever sent to the State. Employee #2 stated, "No." Facility staff failed to report an allegation of possible abuse of a resident by a CNA to the State Agency in accordance with the facility policy. Employee #2 acknowledged the finding.	F 226		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews for six (6) of **39** Stage 2 sampled residents, the facility staff failed to respect residents' dignity while dining as evidenced by:	F 241		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X51 COMPLETION DATE
F 241	Continued From page 23 three (3) residents' sat idle while others at the same table ate their meal, failed to provide one (1) resident dignity by standing and feeding him, and failed to provide one (1) resident dignity by placing a dirty tray on the table while he dined. Also, one (1) resident was observed sitting in the rehabilitation area wearing glasses with a missing lens. Residents' #43,#46,#58,#89,#100, and#132. Findings included... 1. Facility staff failed to provide dignity by allowing Resident #43 to sit idle while others dined at the same table. During a dining observation on the sixth floor on November 6, 2017, at approximately 1:00 PM. Resident#43 sat at a table eating her lunch with her family present. At the same table, Resident# 89 sat idly without any lunch tray. At approximately 1:10 PM, Employee#13 asked why Resident#89 did not have a lunch tray. Employee#13 replied, "He usually eats on the 7th floor." Resident#89 was then removed from the sixth-floor dining room and taken to the seventh-floor dining room for lunch. 2. Facility staff failed to provide Resident#100 dignity by standing and feeding him. During a dining room observation on the sixth floor on November 8, 2017, at approximately 11:45 AM showed Resident#100 seated while Employee#14, CNA stood over Resident#100 while assisting him to eat.	F 241	Residents #43, #46, #58, #89 1. Resident #43- was served her lunch immediately. Resident#46- meal tray was immediately served. Resident#58- meal tray was served immediately, Resident# 89 was immediately removed to the 7th floor, and was served lunch. The involved employees were counseled for failure to respect residents 'dignity by allowing them to sit idle while others were dining and for not redirecting resident to dining area on another floor. Resident #100 - the dirty tray was removed immediately. The involved employee was counseled for failure to respect residents' dignity by standing while feeding and placing a dirty tray on table while the resident dined. Resident #132- the glasses were removed and resident has been scheduled for eye appointment with the ophthalmologist. 2. No other residents were affected by these deficient practices as evidenced by rounds being made by clinical managers/designee to ensure that all staff assigned to the dining room,	11/6/17 11/6/17 11/6/17 12/19/17 Ongoing

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F 241	Continued From page 24	F 241	during meal times are treating residents with dignity and respect, serving residents at the same time, and assisting them with meal consumption.	Ongoing
	3. Facility staff failed to provide dignity by allowing Resident #46 to sit idle while others dined at the same table. On November 8, 2017, at approximately 12:00 PM, a dining observation on the 6th floor occurred. During this time, Resident #102 was eating her lunch tray while Resident #46 sat idly at the same table without a lunch tray. Resident #46's lunch tray arrived at 12:07 PM.		Additionally, all residents wearing eyeglasses were identified to ensure proper fit and no missing pieces.	11/9/17
	4. Facility staff failed to provide Resident #100 dignity by placing a dirty tray on the table while he dined. On November 8, 2017, at approximately 12:40 PM, a dining observation on the 6th floor occurred. During this time, Employee #15, CNA picked up a dirty tray from another resident's table and placed the dirty tray across from Resident # 100 who was still eating his lunch. These observations were shared with Employee #7 on November 8, 2017, at 1:00 PM and she acknowledged the findings.		3. To prevent future occurrences, all nursing staff were in serviced on the provision of care that enhances dignity and respect while assisting residents during meal consumption to ensure compliance. Clinical managers/designee will monitor/observe the dining room daily during meal times to ensure that staff are assisting residents consume their meals and that they are served at the same time to promote enhanced dignity and respect.	12/10/17 and ongoing
	5. During a dining observation, facility staff failed to respect one (1) resident's dignity when serving his lunch meal on November 6, 2017. Resident #58 An observation on November 6, 2017, at approximately 11:55 AM revealed Residents #58, and #63 seated at a dining table together. The		Nursing management and social workers will monitor the ophthalmology appointment logs on each unit daily	Ongoing

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F241	Continued From page 25 facility staff served Resident #63 lunch. However, Resident # 58 did not receive a lunch tray at that time. At approximately 12:03 PM, eight minutes later. an employee approached Resident #58 's table with a tray and stated, "Here is your lunch." Resident #58' s lunch tray was given to him when Resident #63 sat at the table with him was finished eating his lunch. During a face-to-face interview on November 6, 2017, at approximately 12:55 PM with Employee #6. She acknowledged the finding and stated, "Staff knows better. We will in-service them." 6. Facility staff failed to promote care for a resident in a manner that maintains or enhances the resident's dignity. Resident #132. On November 13, 2017, at approximately 10:05 AM, there was an observation of Resident #132 sitting in the physical rehabilitation area of the facility wearing glasses with a missing left lens. A resident interview on November 13, 2017, at approximately 10:10 AM revealed, "I told them that I had the hundred dollars for the glasses but they never told me when I was supposed to go to the eye doctor and I spent the money, see the lens is missing, I need my glasses because I can't see close up it looks blurry." A face-to-face interview with Employee #7 [Nursing Supervisor] on November 13, 2017, at approximately 11:30 AM, "I know he had an eye doctor appointment, but I think it was missed, and	F241	In service was provided to all staff to ensure identification of any resident with missing lens/parts, reporting scheduling ophthalmology appointments for replacement of glasses. 4. Meal time observation and coordination of resident treatment, devices and/or services will be added as nursing quality indicators to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. The DON will report the results of these monitoring/audit reviews to the Assistant Administrator monthly and present with any action plan for improvement to the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Completion date: 12/29/17	12/5/17 Ongoing

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F 241	Continued From page 26 the social worker would know more about it." On Novemb r 13, 2017, at approximately 12:15 PM, during a face-to-face interview with Employee #10 [Social Worker], she states, "Yes, he was sche led for an eye appointment, but his insurance would not cover the full amount, the r ident would be responsible for 20 %, so the appointment was canceled, we need to reschedule the appointment." Employees # 7 and #10 acknowledged the findings.	F 241		
F 244 SS=E	LISTEN/A ON GROUP GRIEVANCE/RECOMMENDATION CFR(s): 483.1O(f)(5)(iv)(A)(B) (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups c o nce rningissues of resident care and life in the f a c lit y. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean thatthe facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based a resident intervi and record review of (one) 1 of 39 sampled residents, th facility staf failed to act upon resident grievances and concerns	F 244	1. Resident Council meeting minutes for August, September and October were provided to the Administrator for review and response/ follow-up on any grievances/complaints that needed to be addressed with residents. Policy for Cell phone use and providing assistance to residents in a timely manner as well as not using resident sitting area as a breakroom were addressed in a staff meeting. 2. No other resident was affected by this deficient practice. All Resident/family satisfaction surveys will be conducted to identify concerns and grievances. Management will provide a response and rationale for such response within seven (7) days of	11/9/17 11/30/17 Ongoing

regarding care and life at the facility.

, receipt.

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F 244	Continued From page 27 Resident # 52. Findings included..... On November 11, 2017, at approximately 10:00 AM a review of the resident council meeting minutes (permission obtained to review) and Resident interview #52, reveal ongoing resident concerns of, staff talking on their cell phones while providing care, waiting for long periods of time for staff assistance and staff using the resident day sitting area as a breakroom. On November 11, 2017, at approximately 11:00 AM an interview with Resident #52 stated "there are ongoing issues in the facility. We talk about it month after month. The issues are all written in the minutes. Only if a problem is observed the staff is counseled on the spot, but for the widespread issues we have to really push staff to get an answer." On November 13, 2017, at approximately 1:00 PM a face-to-face interview with Employee #18 who stated "yes there are ongoing issues and I discuss the issues and concerns at in-services and stand-up meetings with department heads. I will check to see if there is a record of the meetings." Upon further review, there was no documented evidence of the said meetings and or evidence of the facilities actions in response to the resident's grievances regarding the care and life at the facility. Employee#18 acknowledged the findings at the time of the interview.	F 244	3. To prevent future occurrences, the Resident Council president will send an invite when Administrator or another Department is requested to attend. Administrator/Department will also request a meeting with residents to provide updates as needed. Issues related to specific departments will be forwarded for timely resolution. The Therapeutic Recreation and Social Work departments will be re-educated on addressing resident/family grievances and concerns and providing timely feedback/resolution. 4. Audits of resident/family grievances, concerns and resident satisfaction surveys will be added as Social Work and Therapeutic Recreation quality indicators to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17.	Ongoing 11/13/17 Ongoing

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F246	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246	1. Resident #24 received a shower on 11/6/17 and is heduled s w to receive two eekly.	1116111
F246 SS=D	CFR(s): 483.10(e)(3)		2. Shower and personal care schedules were revi d with resident input to ensure their pr ferences are honored. Any id ntified is ues/concerns were addressed. AOL's/personal care will be included in care plan discussions with residents and families.	11/7/17
	483.10(e) R pect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive servic in the facility with reasonable accommodation of resident needs and pref ences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, for one (1) of 39 Stage 2 sampled residents, it was determined that facility staff failed to ensure that Resident #24 received regular showers. Findings include... During a Stage 1 interview on November 7, 2017 at approximately 3:00 PM, Resident #24 was asked whether he chose how many times a week he gets a bath or shower. The Resident resp de They d, " bed. I would like to get some wash me up in the showers. I don't get any." During a face-to-face interview with Employee 6 at approximately 10:00 AM on November 8, 2017, the employee stated that each resident receives at least two sh ers each week and that all of the showers were documented in a binder.		3. To prevent future occurrences, staff will be re-educated on treatment of residents with dignity and respect and commodation of their needs and preferences. The clinical manager/designee is monitoring shower/bath document and randomly observing showers to ensure that schedules are followed.	12/10/17 Ongoing

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F 246	Continued From page **29** The resident's shower sheets were requested on November 13, 2017. The facility provided two (2) sheets for November 10, 2017 and November 11, 2017. According to the documentation the Resident did not receive a shower on either day. Bed baths were documented as given. This writer also reviewed the binder in which the shower sheets are kept, no additional shower sheets were found for the resident. Facility staff failed to ensure that Resident #**24** received regular showers. Employee #**2** was informed of the finding. Based on resident interview and isolated observation for 1 of **39** sampled residents facility staff failed to provide services with reasonable accommodation of individual needs by not responding with timeliness to a call bell for assistance. Findings included... On November 7, **2017,** at approximately 9:30 AM a Resident interview reveal the following response" I have to wait a long time for assistance especially on weekends, they don't have enough help. " On November 7, 2017, at approximately 9:40 AM, Resident #**141** pressed the bedside call button for assistance, and an audible alarm could be heard coming from the nursing station, a red light illuminated from the wall unit. The Resident interview continued, and after ten minutes the	**F246**	4. Monitoring of showers will be added as a quality indicator to the daily stand-up meeting to ensure compliance until 3 consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the DON who will also present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT DF 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)	(XS) COMPLETION DATE
F246	Continued From page 30 resident states "look someone turned off the call bell, the call box is not lit anymore." Upon observation, the call bell wall unit was no longer illuminating, and the Resident was observed to press the call light again. An audible alarm sounded at the nursing station, after five minutes Resident #41, is in a wheelchair and states "the unit clerk told me to tell you to tum off the call light. I am his roommate, and the clerk at the front desk told me to tell you to turn off the light." At no time during the Resident interview (15 minutes) did staff respond to the call light or enter into the Resident's room to provide assistance. On November 7, 2017, at approximately 10:00 AM a face-to-face interview with Employee# 19, Unit Clerk, stated "yes, I told his roommate to tell the person in the room to turn off the light, he told me someone was in the room I did not know it was you the surveyor. I thought it was the CNA because a lot of the time it is them in the room and they don't turn off the call light." Employee # 7, Nursing Supervisor, stated" you should have said something all of the staff around here someone would have gone into the room, we answer call lights around here this is nothing new." The nursing supervisor directed staff to the resident's room. Employee # 7 stated "when the call bell alarms at the nursing station the staff usually answer, but that did not happen this time." Employees # 7 and #19 acknowledged the findings.	F246	**Resident #141**- call light was answered. Employee #7 was immediately counseled regarding the requirement for prompt response to the call-bell. 2. No other resident was affected by this deficient practice 3. To prevent future occurrences, all staff was inserviced on timely response to call lights. The DON and Unit Managers will be monitoring and follow-up as needed to ensure timeliness of response and compliance. 4. Monitoring of call light response time will be added as a nursing quality indicator to ensure compliance. Results of the audits will be reported monthly to the Assistant Administrator by the DON and presented quarterly at the Quality Assurance committee meeting. The QAC will ensure oversight and correction of identified deficiencies 5. Corrective Action completion date: 12/29/17	11/7/17 11/7/2017 11/9/17 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

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F 253	Continued From page 31	F 253	1. **Resident #24** was not harmed by the deficient practice.	
F253	HOUSEKEEPING & MAINTENANCE SERVICES	F 253		
SS=D	CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by. Based on an observation on November 8, 2017, at approximately 10:00 AM, the facility staff failed to provide housekeeping and maintenance services necessary to maintain the Resident's room in a sanitary, orderly, and comfortable manner, in four (4) of four (4) observations, as evidenced by: a stained curtain that served as a room divider, wrinkled sheets and no spread on Resident #24's bed, dusty bed rails and frame and dust and tiny deceased insects in the over bed light . Findings include... During a tour of Resident# **24's** room on November 8, 2017, at approximately 10:00 AM, the follwing were observed; one (1) of one (1) stained privacy curtain that served as a room divider one (1) of one (1) set of wrinkled sheets and no spread on the Resident 's bed one (1) of one (1) bed with dusty bed rails and frame one (1) of one (1) over-the-bed fight contained tiny deceased insects The observations made in the presence of		The stained privacy curtain was replaced. A spread has been placed on the residents' bed and the wrinkled sheets were replaced. The bed with dusty bed rails and frame was cleaned. The over the bed light that contained tiny deceased insects has been removed and cleaned. **2.** The Director of Environmental Services will make rounds on all resident rooms to ensure that a sanitary, orderly and comfortable interior is maintained. **3.** To prevent future occurrences, all environmental services staff has been re-educated on the 10-step cleaning process, to ensure compliance. **4.** Resident Room observation is an Environmental Services quality indicator that will be used to ensure compliance.	11/8/17 **Ongoing** 11/8/17

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F 253	Continued From page 32 Employee #6 at approximately 11:00 AM on November 9, 2017, were acknowledged.	F 253	4. (cont'd) Results of the audits will be reported to the Assistant Administrator and presented by the Director of Environmental Services at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: *12/29/17*	
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING | (X3) DATE SURVEY COMPLETED 11/14/2017

NAME OF PROVIDER OR SUPPLIER: UNITED MEDICAL NURSING HOME

STREET ADDRESS, CITY, STATE. ZIP CODE: 1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

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F 280	Continued From page 33 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 2aol	1. The care plan for Resident #122 was revised to include goals and approaches for the resident non-compliance with medication treatment plan. 2. All other residents have the potential to be affected by this deficient practice. Medical records of all residents refusing or non-compliant with medication treatment plan were audited to ensure a corresponding care plan is included for resident non-compliance with his/her medication treatment plan 3. To prevent future occurrence, the IDT team were re-educated on care plan updates as they relate to resident non-compliance with plan of care.	11/7/17 11/7/17 11/9/17

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F 280	Continued From page 34 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 sampled stage 2 residents, the facility staff failed to review/revise the care plan to include goals and approaches for the management of Resident # 122, noncompliant with medication treatment plan. Finding include... A review of the resident's nursing progress notes revealed Resident #122 refused Sertraline 150 mg one (1) daily for depression on July 13, 2017 and refused Depakote 500 mg two (2) times daily on July 24, 2017. The clinical record lacked evidence that staff updated the care plan to incorporate measures to manage episodes of medication treatment plan noncompliance. Employee #1 acknowledged the findings during a face-to-face interview conducted on November 14, 2017, at approximately 11:00 AM.	F 280	4. Audits of care plan updates for resident noncompliance will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans	F 281		

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F 281	Continued From page 35 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview of one (1) of 39 Stage 2 sampled residents, the facility staff failed to check gastrostomy (G-tube) placement prior to administration of medication; and administer eye drops in accordance with accepted professional standards of quality during Medication Administration for Resident #54. The findings include: 1. Facility staff failed to check G-tube placement prior to administration of medication in accordance with accepted professional standards of quality during Medication Administration Observation for Resident #54. According to The Lippincott Manual of Nursing Practice, Seventh Edition, "To check for tube patency and position remove the cap or plug from the feeding tube and use the syringe to inject 5 to 10 cc of air through the tube. At the same time, auscultate the patient's stomach with the stethoscope. Listen for a whooshing sound to confirm tube positioning in the stomach. Also, aspirate stomach contents to confirm tube patency and placement," (p. 1463). During medication administration observation on	F 281	1. **Resident #54** was observed and not harmed by this deficient practice. A medication error incident report was completed. The involved nursing employee was re-educated regarding failure to check gastrostomy G-tube placement prior to administration of medication and administering eye drops in accordance with accepted professional standards. 2. Medpass observations of staff were conducted during administration of eye drops and medication via gastrostomy G-tube to ensure administration in accordance with accepted professional standards. 3. To prevent future occurrence, all medication nurses were re-educated to ensure administration of eye drops and medication via G-tubes in accordance with accepted professional standards and to ensure compliance.	11/7/17 11/7/17 11/9/17

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F 281	Continued From page 36 November 6, 2017, at 9:40 AM, Employee#26 checked for residual by placing 10 cc syringe into the G-tube, pulling back on the plunger with no residual noted. Employee#26 administered these medications to Resident# 54 via the G-tube: Thorazine 50mg [anti-psychotic-mental mood disorder], Loratadine 10mg [Antihistamine -allergy symptom], Magnesium Oxide 400mg, Folcaps [folic acid/vitamin 86/812] one (1) capsule, Potassium Chloride 20mcq/15ml (30ml) [mineral supplements], and Lactulose 30ml {constipation] via G- tube. Employee#26 failed to auscultate the patient' s stomach with the stethoscope and listen for a whooshing sound to confirm tube positioning in the stomach and to check for G-tube placement prior to the medication administration. 2. Facility staff failed to administer eye drops in accordance with accepted professional standards of quality during medication administration observation for Resident#54. "Place the back of your thumb against the forehead, above the eye receiving the drop Tilt head backward with both eyes open, and look at a point on the ceiling. Pull lower lid down gently to form a pocket for the drop. Position the tip of the eye drop bottle so that it does not come closer than ¾ inch above your lower lid. Squeeze the bottle lightly to allow the drop to fall into the pocket. 10. Close eyes without squeezing them. Keep your eyes closed, and gently blot them with a clean tissue. With eyes closed, gently press on the inner part of the eye for 30 seconds. This keeps the medication in contact with the eye longer." clinicalcenter.nih.gov/ccc/patient_education/pepu	F 281	4. Monitoring of administration of medication via G-tube and eye drops will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator by the DON who will also present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	*Ongoing*

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F 281	Continued From page 37 bs/eyedrops.pdf During medication administration observation on November 6, 2017, at 9:40 AM, Resident #54 was already lying in bed. Employee #26 was observed to pull on his upper eyelids one at a time, squeezed the eye drops medication bottle, Resident #54 eye drops missed the eyes and ran down his cheeks. A face-to-face interview conducted with Employee #6 and Employee #26 on November 6, 2017, at approximately 9:55 AM. Employee #6 listened to the concerns presented and acknowledged the findings by reporting that staff is a new graduate we will educate her.	F 281		
F 312 SS=D	AOL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interview for two (2) of 39 Stage 2 sampled residents, facility staff failed to assist one (1) resident to maintain appropriate grooming; and failed to ensure one (1) resident who was unable to carry out their own activities of daily living receive incontinent care. Residents' #39 and #115. Findings include ...	F 312	1. **Resident #39** had his clothes changed. 2. Clothes of all residents was inspected for stains and holes. Any identified issues were addressed. 3. To prevent future occurrences and to ensure compliance, staff will be re-educated on performance standards for assisting residents with ADLs. The clinical manager/designee is monitoring shower/bath documentation, schedules and grooming. AOL's and personal care will be included in care plan discussions with resident and families. 4. Monitoring of resident grooming, shower documentation, schedules will be added as a nursing quality indicator	11/9/17 11/9/17 12/5/17 **Ongoing**

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F 312	Continued From page 38	F 312	to ensure compliance. Results of the audits will be reported by the DON to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. S. Corrective action completion date: 12/29/17. **1. Resident #llS's** room has been cleaned, waxed and disinfected. **2.** All resident shower schedules were reviewed to ensure that residents' preferences are honored. **3.** To prevent future occurrences, a resident focus meeting was held with the CNAs re: grooming, shower schedules and incontinence care to ensure compliance. **4.** Incontinence care will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly, by the DON, to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will have oversight and correction of identified deficiencies. **5.** Corrective action completion date: 12/29/17	**Ongoing** 11/7/17 12/5/17 **Ongoing**

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(X4) 10 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 312	Continued From page 39 dependent on staff for personal hygiene and bathing. Under Section H: Bladder/Bowel, the resident was coded as always incontinent of urine. Facility staff failed to ensure that Resident #115 received personal hygiene consistent with the resident's needs. During an interview with Employee #2 at the time of 4: 15 PM observation. The Employee acknowledged that the resident's incontinent brief was urine soaked and the room smelled of urine.	F312		
F313 SS=D	TREATMENT/DEVICES TO **MAINTAIN** HEARINGNISION C FR(s): 483.25(a)(1)(2) (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview for one (1) of 39 sampled residents facility staff failed to ensure resident receive proper treatment and assistive devices for vision by failing to reschedule an eye appointment.	F313		

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F 313	Continued From page 40 Findings included.... On November 13, 2017, at approximately 10:05 AM a resident interview reveals, "They were supposed to make an eye appointment for me, I had the hundred dollars for the glasses, but I spent it, I can't see close up because it's blurry." On November 13, 2017, at approximately 10:30 AM a clinical record review reveal a verbal order with a date of September 4, 2017, appointment scheduled for opth [opthamology] on September 5, 2017, at 9:30 am. On November 13, 2017, at approximately 11:00 AM, a review of the Minimum Data Set [MOS] with a date of August 26, 2017, under Section B 1200 {Corrective lenses (contacts, glasses, or magnifying glass)] the allocated space has a number 1 which indicate Yes. A further review of the record indicate a daily progress note with a date of September 15, 2017, reads "resident missed appointment today because the insurance said he need to pay 20% out of his pocket." On November 9, 2017 at approximately 11:00 AM, a face-to-face interview with Employee# 21, stated that " I make all of the appointments and follow-up appointments, I schedule the appointments two days before so that they can run the insurance, in the resident's case he needed to pay 20% and the appointment was canceled we told his daughter but I did not reschedule another appointment" A face-to-face interview with Employee# 10 [social worker] on November, 2017, at	F 313	1. Resident #132 has a scheduled Eye appointment. 2. No other resident was affected by this deficient practice. The facility has audited all resident records with vision issues requiring intervention. Appropriate consults will be requested per audit findings. Nursing management, DON, clinical managers, social workers and supervisors will review the ophthalmology appointment logs on each unit daily. 3. To prevent future occurrences nursing staff will be in-serviced regarding vision services, how to obtain consults and coordination of family/resident requests for consultation to attending physicians to ensure appointments are made and residents attend the consults. 4. Coordination of resident treatment, devices and/or services required to maintain hearing/vision will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved.	1/12/18 11/20/17 Ongoing 12/10/17

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F 313	Continued From page41 approximately 11:30 AM stated that "yes, he was scheduled for an eye appointment, but his insurance would not cover the full amount, the resident would be responsible for 20 %, so the appointment was canceled, we did not reschedule the appointment." Employee #10 acknowledged the findings at the time of the interview	F 313	The audits will be conducted by the unit managers weekly. Results of the audits will be reported monthly to the Assistant Administrator by the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies 5. Corrective action completion date: 12/29/17.	Ongoing
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s):483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 39 sampled residents, the facility staff failed to ensure that residents were free from physical abuse as evidenced by Residents' #23 and 101 who experienced one (1) occasion of physical abuse by Resident #122. Findings include... Resident # 122 was admitted to the facility on June 22, 2017. According to the history and physical dated June 23, 2017, Resident #122 has the following diagnoses: exacerbation of multiple sclerosis, bipolar disorder, insomnia, chronic pain disorder, schizoaffective disorder with psychotic features, and narcissistic personality disorder. Review of the medical record on November 14, 2017, showed Resident #122 had altercations with two (2) residents, one on August 14, 2017, and another on November 7, 2017. 1. Facility staff failed to keep the Resident #23 free from abuse when Resident #23 had coffee" thrown in her face by Resident # 122 on August 14, 2017, at 2:50 PM during activities in the common day room. A review of the medical record on November 14, 2017, revealed the following: Nurse's progress note entry, August 14, 2017, at	F323	1. **Resident# 23 and #101-** An incident report was completed regarding the reported resident to resident physical abuse by **Resident #122.** 2. **Resident #122's** behavior is being monitored by the nursing staff and when behavior has changed, the attending physician is notified, as well as the psychiatrist for evaluation. 3. To prevent future occurrences, in-service training was provided to all department heads and all nursing staff. Daily review of reported resident to resident altercations will be conducted at the daily stand-up meeting to ensure that reported resident to resident altercations have a corresponding incident report on file, and are care planned with appropriate approaches. Efforts to Identify outside resources will continue to identify possible solutions	8/14/17 Ongoing 12/5/17 On-going

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	{X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4)10 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)	(XS) COMPLETION DATE
F 323	Continued From page 43 2:50 PM, "At approximately 2:50 PM while participating in activities with fellow residents and an activity staff member, coffee was poured on resident by one of the fellow residents." A review of the Care Plan section of Resident#23 's clinical record revealed no evidence of interventions to address the altercation which occurred on August 14, 2017. A face-to-face interview was done on November 13, 2017, at 10:00 AM with Resident#23. When questioned about the incident, she stated, "I was shocked when [Resident#122] threw the coffee in my face because I told [Resident#122] that he does not live on this floor. I was glad the coffee was cold. [Resident#122] did apologize to me and I don't feel afraid of [Resident#122]." A review of the clinical record lacked evidence that facility staff implemented interventions to ensure that Resident#23 was free from future physical altercations. A face-to-face inteiview was conducted with the Employees'#1,#2, and#3, on November 14, 2017, at approximately 11:00 AM. When questioned, they acknowledged there were no interventions in place to prevent future occurrences of this incident. 2. Facility staff failed to keep the Resident#101 free from abuse when he had water" thrown in his face by Resident# 122 November 7, 2017, at 3:40 PM during activities in the common day room on the 6th floor.	F323	(#3 cont'd) Discharge planning for **resident #122** is ongoing Resident is seen by the psychiatrist monthly and as needed for impulsive/aggressive behavior. To ensure safety for other residents and to address resident's sporadic behavior: Staff has been assigned to monitor dayroom. Hourly rounding will be conducted by unit staff to identify resident location and activity. Unit Staff is also assigned to monitor Healing Garden. Security monitors the front entrance of the building, closely monitors via camera, the areas that resident frequents for quick response (CEO's office, Administrator's office, front entrance of the building, healing garden and unit). Security also frequently rounds on the unit to identify unusual activity. A standing MD order will be written for refusal of medication. Unit Manager/designee and Director of Recreation Therapy/designee are to be notified. Resident will then be redirected from group therapv to an	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing

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F323	Continued From page44 A review of the medical record on November14, 2017, revealed the following: Nurse's progress note entry, dated November7, 2017, showed the facility staff entered the day room at about3:40 PM where Resident# 101 and Resident#122 engaged in a verbal altercation and Resident#122 poured drinking water onto Resident #101. A review of the Care Plan section of Resident#101 and Resident#122's clinical records revealed no evidence of interventions to address the altercation, which occurred on November17 ,2017. During an interview with Resident#101 on November13, 2017, at10:00 AM, the resident stated, Yes, [Resident#122] poured the water, but I'm okay and don't have a problem with him and I'm not afraid of him. A review of the clinical record lacked evidence that facility staff implemented interventions to ensure that Resident#101 was free from future physical altercations with Resident#122. During a face-to-f ace interview with the Employees #1, 2, and,3 on November14,2017, at approximately11 :00 AM, they acknowledged there were no interventions in place to prevent future occurrences of this incident.	F323	individually structured activity in the Healing Garden. This Plan has been discussed with resident, who has agreed. Signed agreement will be placed in medical record. The Director of Recreation Therapy /designee will meet with resident daily to identify any concerns/needs Resident will be referred to anger management class 4. Behavior monitoring of residents with challenging behaviors will be added as a nursing quality monitor for review at daily stand up meetings to ensure that all residents are free from physical abuse from other residents and to ensure compliance. Results of the audits will be reported monthly to the Assistant Administrator by the DON who will also report to the qua rterly Quality Assurance comm ittee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	Ongoing
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY CFR(s):483.60(i)(1)-(3)	F371	5. Corrective action completion date: 12/29/17	

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F371	Continued From page 45 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to store foods under sanitary conditions as evidenced by: (1) of (1) wrapped beef tenderloin was stored beyond the expiration date; (1) of (1) undated wrapped boneless pit ham and (1) of (1) turkey breast was undated; (1) of (1) container of squid storage beyond expiration date, (1) of (1) undated wrapped meat and (1) of (1) piece of unwrapped frozen biscuit inside reach-in freezer. Also, in the dry storage area, (1) of (1) box of thickened apple juice had an expired date and (2) of (2) boxes of Similac soy isomil infant formula was stored beyond the expiration date.	F371	I. No resident was hanned by this deficient practice. All food not stored under sanitary conditions was removed 2. The leadership team is conducting weekly documented visual inspections to ensure safety and sanitation 3. To prevent future occurrences, staff will be in-serviced and trained on proper storage, dating & labeling of food items to ensure compliance. This training will also address expiration dates, how and when to discard these items. The Leadership team will monitor through weekly documented inspections. 4. Storage of foods under safe and sanitary conditions will be added as a dietary quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly to the Assistant Administrator by the Director/designee and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure	11/9/17 Ongoing 12/29/17 Ongoing

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F 371	**Continued From page 46** **Findings include ...** **(1) of (1) wrapped beef tenderloin had a label of "10/24, good through 10/27" was found inside the kitchen's walk-in refrigerator#2.** **(1) of (1) undated wrapped boneless pit ham and (1) of (1) undated wrapped turkey breast was observed Inside walk-in refrigerator# 2** **(1) of (1) container of squid was observed on the floor with a preparation date of 10/25** **(1) of (1) undated wrapped meat inside reach-in freezer# 1** **(1) of (1) piece of unwrapped frozen biscuit inside reach-in freezer# 1** **During the tour of the dry storage area on November 9, 2017 at approximately 12:30PM, the following were observed:** **(1) of (1) box of thickened apple juice had an expiration date of 10/2/2017** **(2) of (2) boxes of Similac soy isomil infant formula had an expiration date of 11/1/2017** **Dunng the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, Employees#16 and#17 acknowledged the findings.**	F 371	The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	
F 372 SS=D	**DISPOSE GARBAGE & REFUSE PROPERLY** **CFR(s): 483.60(i)(4)**	F 372		

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F 372	Continued From page 47 (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly dispose of garbage (food waste) refuse as evidenced by a meat and paper disposed of in the same receptacle in one (1) of one (1) observation. The observation was made on November 6, 2017, at approximately 9:15 AM In the presence of Employee #16. Findings include ... 1. During the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, food and trash were mixed in a trash receptacle outside walk-in refrigerator #2. The items consist of chopped pink meat, paper and plastic inside the trash receptacle. 2. During the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, it was also observed that the food trash container was mixed with regular trash outside walk-in refrigerator #2. Employee #16 acknowledged the findings at the time of the observation.	F372	I. The deficient practice was corrected immediately. 2. No resident was hanned by this deficient practice. "The Trim Tracks Food Waste Observation" program has been implemented and is being championed by the Executive Chef and the Patient Services Manager to ensure that residents will not be affected. 3. To prevent future occurrences, and to ensure compliance, staff will be in-service and trained on proper disposal of waste. The Director will monitor by conducting weekly documented reviews of this process. 4. Disposal of waste will be added as a dietary quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly by the Director to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	12/10/17 12/10/17 Ongoing Ongoing
F 406 SS=D	PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES CFR{s): 483.65(a)(1)(2) (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and	F406		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONSTRUCTION A, BUILDING B. WING	(X3)DATE SURVEY COMPLETED
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F406	Continued From page 48 rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(9), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, for one (1) of 39 Stage 2 sampled residents, the facility staff failed to assure that Resident #2 receive necessary specialized rehabilitative adaptive devices to assist with eating meals independently. Findings include... An observation on November 6, 2017, at approximately 12:15 PM showed Resident #2 with a fork in his right hand attempting to eat his meal having difficulty scooping the food onto the fork. On November 7, 2017, at approximately 12:30 PM, the facility staff served Resident #2 the meal at the bedside. Again, the resident could not pick up the food with the fork. The food slid off the standard plate onto the tray. Resident put the	F406	1. **Resident #2** has been evaluated by occupational therapy. 2. An audit of all residents in need of specialized rehabilitative adaptive devices to assist with eating meals independently was done to ensure that the resident was referred to and evaluated by occupational therapy. 3. To prevent future occurrences and to ensure compliance, all nursing staff has been re-educated to ensure that all residents in need of adaptive devices should be referred to occupational therapy for screening and evaluation, as one of the approaches to be documented in the resident's care plan.	12/5/17 12/5/17 12/5/17

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F 406	Continued From page 49 fork down. A staff member came around at this time and offered him a sandwich. The resident agreed to have the sandwich and ate it without difficulty. Review the medical record on November 9, 2017, showed a MOS (Minimum Data Set) Comprehensive assessment dated August 23, 2017. In Section G. Eating- was coded as supervision with eating which means oversight or encouragement and cueing with set up help only. There was no indication that resident had been assessed for his ability to eat independently without additional device help. During a face to face interview with Resident # 2 at approximately 1:15 PM on November 7, 2017 he stated that sometimes he has trouble getting it to his mouth and using his fingers and hand to eat sandwiches is easier. During a face-to-face interview on November 9, 2017, at approximately 10:00 AM with Employee #25, she stated the resident had been on rehabilitation service in August 2017 for grooming but was no longer on service. When asked if the resident had been evaluated for use of fork or an adaptive device to help him with his meals she stated "No." Employee #25 acknowledged the findings. The clinical record lacked documented evidence	F 406	4. Assessment audits to identify, determine resident needs for specialized rehabilitative adaptive meals devices and to assist with eating independently, will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Rehabilitation consults will be generated as needed. Results of the audits will be reported monthly to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting by the Director of Rehabilitation. The QAC will ensure oversight and correction of any identified deficiencies 5. Corrective action completion date: 12/29/17	Ongoing

D PARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING B WING	(X3) DATE SURVEY COMPLETED
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F 406	Continued From page 50 that facility staf assess Resident # 2 to determine his highest practical level of function and psychosocial well-being, to facilitate ating, prior to the observations and subsequent interviews.	F 406		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A sys m for preventing, identifying, reporting, investigating, and controlling infections and c mmunicable diseases for all residents, staf, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70 e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441	1. **Resident# 28** was not harmed by the deficient pr ctice. Resident was educated on hand hygiene and sanitizer use prior to eating. Employee #6 was re-educated on hand hygiene procedures to be followed by staf involved in direct re ident contact and proper sanitary set-up of resident's food. 2. No other residents affected by this deficient practice. Hand hygiene observation rounds were made by the ICP to ensure that staff were following professional standards and facility policies and procedures.	12/5/17 Ongoing

communicable disease or infections should be reported;

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 095039

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 11/14/2017

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PREFIX TAG (X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES	PREFIX TAG ID	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDER'S PLAN OF CORRECTION DEFICIENCY)	COMPLETION DATE (XS)
F 441	Continued From page 51 (iii) Standard and tra smission-bas precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, 1f direct contact will transmit the disease; and (vi) The han hygiene procedures to be staf involved in direct resident contact. followed by (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transpot linens so as to prevent the spread of infection. (f) Annual r view . The facility will conduct an an nual review of its IPCP and upd ate their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on obser vation and st f interview, facility staf failed to ensure proper hand hygiene practice for one (1) resident during a dining observation.	F 441	3. To prevent future occurrence, all nursing staff were in serviced on Hand hygiene , with return demonstration to ensure compliance and that proper hand-washing protocol, professional standards are consistently followed. 4. Employee hand-washing practice/audits will be added as an Infection Control quality indicator to ensure compliance. Results of the audits will be reported monthly to the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	12/5/17 Ongoing

Resident #28.

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F 441	Continued From page 52	F 441		
	Findings include ...			
	"Evidence supports the belief that improved hand hygiene can reduce health-care-associated infection rates. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of multiresistant organisms and has been recognized as a substantial contributor to outbreaks."			
	http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf#page=19			
	Dunng a dining observation conducted on November 7, 2017, at approximately 12:15 PM, Resident #28 was observed to use both hands to roll his wheelchair into the day room/dining area. Staff brought his lunch and placed it before him but did not offer him hand sanitizer to cleanse his hands. Resident #28 observed eating his lunch. The Surveyor stated to the resident, "You are late getting lunch." The resident responded, "I was outside."			
	A face-to-face interview was conducted with Employee #6 on November 7, 2017, at approximately 12:50 PM concerning residents not offered the opportunity to perform hand hygiene prior to eating lunch. Employee #6 acknowledged the finding.			
F 463 SS=D	RESIDENT CALL SYSTEM • ROOMS/TOILET/BATH CFR(s): 483.90 (g)(2)	F463		
	(g) Resident Call System			

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F 463	Continued From page 53 The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to maintain call light in good working condition as evidenced by the call light failure to produce an visual or audible sound to alert the staff in one (1) of 39 resident's rooms. Resident #54 Findings include... During an interview at approximately 2:36 PM on November 6, 2017, with Resident #54, the call light was initiated. At approximately 3:30 PM the interview ended, however, the staff did not respond to the call light. The surveyor spoken with the facility staff located at the front desk, to report the call bell issue. The facility staff stated that the bell did not ring and the light outside room 729 did not come on. In reponse to the call bell light failure, the front desk asked another staff member to go back to room 729 and put the call light on again. The call light failed to illuminate or produce an audible sound. The staff sent a report to the maintenance supervisor. During a face-to-face interview with Employee #6 on November 8, 2017, at approximately 2:10 PM regarding the call light not working. She acknowledged the finding and maintenance fixed	F 463	1. **Resident# 54** was not harmed by the deficient practice. Call-lights in room 729 were repaired to give both audible and visual signal. 2. Call-lights in all resident room and bathing areas were checked and corrected as needed. 3. To prevent future occurrences, Building services and clinical staff were re-educated on the safety issues and requirements of functional alarms and call-bells. Staff was also educated on the repair request process to ensure timely repairs 4. Call lights will be added as a quality indicator for the Building Services department and will be monitored during weekly scheduled surveillance rounds. Results of the audits will be reported to the Assistant Administrator monthly and at the Quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	1111111 1111111 11/9/17 ongoing

D ARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4)1D PREFIX TAG	SUMMARY STAT MENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	I D PRE FIX TAG	PROVIDE 'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 463 F 514 SS=D	Continued From page 54 the call light. RES 1 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted profes onal standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) Th comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resi ent review aluations and determinations conducted by the State; (v) Physici n's, nurse' and other licensed professional's progress notes; and (vi) Laboratory, r iology and other diagnostic services reports as required under §483.50.	F463 F 514/	5. Corrective action com pletion date: 12/29/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 095039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B.WING | (X3) DATE SURVEY COMPLETED 11/14/2017

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F 514	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 39 Stage 2 sampled residents, the facility failed to ensure a Licensed Practical Nurse and Registered Nurse signed and verified that an admission assessment was completed for Resident ***#144.*** Findings included... 1.Facility failed to ensure a licensed practical nurse and registered nurse signed and verified that an admission assessment was completed for Resident ***#144.*** Resident #144 admitted on November 3, 2017 at 6:10 PM with diagnoses to include Cerebral Vascular Accident (CVA) with right sided weakness, Hypertension, Bipolar Depression, Seizure Disorder, Vascular Dementia. Review of Resident #144's Resident Admission Evaluation showed the admission evaluation form was left blank for the oral status assessment, inoculation (pneumonia and flu vaccination) assessment, nutrition assessment, side rail recommendations and the use of devices (e.g. cane, walker), indicating the aforementioned assessments were not completed by a nurse on admission. In addition, pages one (1) and two (2) of the Admission Evaluation form lacked the name and signatures of the licensed practical nurse and registered nurse responsible attesting to the form completion.	F 514	**1.** The involved nursing employees were counselled for failure to accurately verify that an admission assignment was completed and signed for **Resident #144.** **2.** Medical records of residents admitted in the last 6 months were reviewed to determine if an assessment was done upon admission to the unit, completed and signed by a registered nurse. **3.** To prevent future occurrences, nursing staff was in-serviced to ensure that all residents admitted are assessed by an RN upon admission and to ensure compliance. Daily audit of medical records of new admissions will be completed by the Admissions Coordinator, to ensure assessments are accurately documented to depict findings according to actual sequence of events during admission and documented by an RN. **4.** Auditing the medical record for new admissions will be added as an admissions quality to ensure compliance until three months of greater than or equal to 95% compliance is	**11/8/17** **11/9/17** **11/9/17** **Ongoing** **Ongoing**

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NAME OF PROVIDER OR SUPPLIER	095039	STREET ADDRESS, CITY, STATE, ZIP CODE	11/14/2017
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F 514	Continued From page 56 Employee#2 on November 13, 2017 at 3:40PM acknowledged the findings.	F 514/	Achieved. Results of the audits will be reported monthly to the Assistant Administrator and presented by the Admissions Coordinator at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 5201		

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F 520	Continued From page 57 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the quality assessment and assurance committee meeting sign-in sheets and staff interview, the facility staff failed to ensure a Director of Nursing Services was present at one (1) of three (3) quality assessment and assurance committee meetings. Findings include ... The facility staff failed to ensure a Director of Nursing Services was present at one (1) of three (3) quality assessment and assurance committee meetings. A review of the quality assessment and assurance committee meeting sign-in sheets revealed that on April 26, 2017 a Director of Nursing Services did not sign the sheet indicating they were not in attendance. During a face-to-face meeting with Employee #3 on November 14, 2017 at approximately 3:31 PM. She stated during this time the facility did not have a Director of Nursing Services and acknowledged the findings.	F 520	1. A new Director of Nursing was hired in June. DON attendance at Quality Assurance Committee meetings has been addressed with the administration. 2. DON/designee attendance at Quality Assurance Committee meetings has been addressed with SNF Administrator. Assistant Administrator will ensure DON attendance. 3. To prevent future occurrences, meeting schedules will be coordinated with the Director of Nursing or designee, who will ensure DON attendance. 4. DON attendance at all QA and Assurance Committee meetings will be monitored and reported to the Director of Hosp ital Quality/Administrator for appropriate follow up as indicated. 5. Corrective action completion date: 12/29/17	11/14/17 Ongoing Ongoing Ongoing