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

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| **UNITED MEDICAL NURSING HOME** | **1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032** |

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| F 000 | INITIAL COMMENTS | F 000 | | |

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
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)

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

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<br>G-tube Gastrostomy tube<br>HSC Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - interdisciplinary team<br>L - Liter<br>Lbs - Pounds (unit of mass)<br>MAR - Medication Administration Record<br>MD- Medical Doctor<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>MN midnight<br>Neuro - Neurological<br>NP - Nurse Practitioner<br>PASRR - Preadmission screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>PO- by mouth<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt - Patient<br>Q- Every<br>QIS - Quality Indicator Survey<br>Rp, R/P - Responsible party<br>SCC Special Care Center<br>Sol- Solution<br>TAR - Treatment Administration Record | F 000 | | |
| F 684 SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to | F 684 | An investigation was completed and the involved nurse was terminated.<br><br>The record for resident #1 cannot be amended retrospectively. The resident expired on July 26th, 2017. | 8/30/17 |

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| F 684 | Continued From page 2<br>facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on medical record review, policy review, and staff interview, the facility failed to perform a respiratory assessment in conjunction with the administration of an "as needed" nebulization respiratory treatment and failed to assess resident for physiological and behavioral signs and symptoms of distress to facilitate prompt interventions to address changes in condition for Resident #1.<br><br>Findings included ...<br><br>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."<br><br>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.<br><br>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.<br><br>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.<br><br>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<br><br>2/1/18<br><br>2/9/18<br>Ongoing |

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| F 684 | Continued From page 3<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>5. Corrective action completion date: 2/ 9 /18 | |

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| F 684 | Continued From page 4<br>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.<br><br>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.<br><br>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."<br><br>Rigor Mortis Reference:<br>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 684 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | F 842 | 1. The record for Resident #1 cannot be amended retrospectively. The resident expired on July26, 2017. | |

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| F 842 | Continued From page 5<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only 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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>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.<br><br>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<br><br>2/9/18 and on-going |

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| F 842 | Continued From page 6<br>by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on facility correspondence, record review and staff interview, for one (1) of six (6) sampled residents; the facility staff failed to accurately assess Resident #1's clinical condition when the resident became unresponsive.<br><br>Findings included:<br><br>Resident #1's most recent admission on June 18, 2017, to the facility included diagnoses of Exacerbation of Chronic Obstructive Pulmonary | F 842 | 3. (Cont'd)<br>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.<br><br>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<br><br>4. Monitoring resident comprehensive assessments, resident care plans to ensure 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.<br>The QAC will ensure oversight and correction of any identified deficiencies.<br>5. Corrective action completion date: 2/9/18 | Ongoing<br><br>Ongoing<br><br>Ongoing |

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| F 842 | Continued From page 7<br>Disease (COPD) and Right Lower Lobe Pneumonia.<br><br>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 Perles capsules 100 milligrams three (3) times a day for a cough until August 10, 2017.<br><br>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 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).<br><br>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 | F 842 | | Ongoing |

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| F 842 | Continued From page 8<br>treatment.<br><br>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."<br><br>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.<br><br>The findings reviewed with Employee #1, Director of Executive Vice President/Chief Nursing Officer, acknowledged the findings. | F 842 | | |