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

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 B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE 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) COMPLETION DATE
K 000	INITIAL COMMENTS During the Life Safety Code Inspection at your facility on January 25, 2011, the following deficiencies were cited based on observation, record review and staff interview.	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that penetrations were observed in wall surfaces above ceiling tiles in hallways and common areas in two (2) of 12) observations on the sixth floor. The findings include: 1. A 1-2 inch penetration was observed around a wire penetrating through wall surfaces on the 6th Floor near room 650 in one (1) of six (6) observations at 2:15 PM on January 25, 2010.	K 017	1. The 1-2 inch penetration that was observed around a wire penetrating through wall surfaces on the 6th floor near room 650 was filled in. * The 6x12 inch penetration that was observed in wall surfaces above the fire alarm box on the 6 th floor west side was filled in. 2. All other areas that could have been affected by this type of deficiency were checked and no other penetrations were found. 3. The Maintenance Director or designee will make round to check for penetrations in wall surfaces above the ceiling tiles in hallways and common areas monthly. 4. Findings from these rounds will be reported at the Quality Assurance meeting in March 2011.	03/06/11

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

Leonard M. Smith Jr. — Administrator — 2/28/11

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K 017	Continued From page 1 2. A 6 X 12 inch penetration was observed in wall surfaces above the fire Alarm box on the 6 h Floor West side in one (1) of six (6) observations at 2:45 PM on January 25, 2011.	K 017		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that resident's rooms and double doors failed to close when tested in three (3) of 22 observations. The findings include: Entrance doors to resident ' s rooms failed to	K 018	1. The entrance doors that failed to latch and close into the frames rooms 625, 719, and 724 were repaired during the time of the survey. 2. All other resident doors were Checked for this deficiency and no others were found. 3. The Maintenance Director or designee will make round to check for resident doors for latching and closing into the frame. 4. Findings from these rounds will be reported at the Quality Assurance meeting in March 2011.	03/06/11

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K 018	Continued From page 2 latch and close into frames when tested at the entrances to rooms 625, 719 and 724 in three (3) of 22 observations between 1:47 PM and 2:45 PM on January 25, 2011.	K 018		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation during the manual fire alarm test, it was determined that staff failed to remove all equipment from the hallway during the drill in one (1) of two (2) observations. The findings include: A manual fire alarm test was conducted on the sixth floor by activating the pull station near the Nurses Station; it was determined that staff failed to remove equipment from the hallway in a timely manner after the drill was underway for 4-5 minutes; a transport cart was left unattended in the hallway near the 6th Floor Storage Room in one (1) of two (2) observations at 3:30 PM on January 25, 2011.	K 050	1. No resident was negatively affected by this deficient practice. 2. All clutter was removed from the Hallways Including a transport cart left unattended. 3. The administrator or designee will reeducate the nursing center staff in the proper procedures for fire drills. 4. The staffs progress will be reported to the Quality Assurance Committee in March 2011.	03/06/11
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 3 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations and interview during the Life Safety Code Inspection, it was determined that Fire Alarm Devices were not tested and maintained on a quarterly basis as required in three (3) of four (4) observations. The findings include: Documentation was available during the Life Safety Code Inspection to substantiate that Fire Alarm Devices including water flow, pressure switches and devices that provide audible and visual signals were not tested on a quarterly basis as required between January 2010 and August 2010 in three (3) of four (4) observations between 11:30 AM and 4:30 PM on January 25, 2011.	K 052	1. No resident was negatively affected by this deficient practice. 2. The Fire alarm devices including water flow, pressure switches and devices that provide audible and visual signals were tested. 3. The Maintenance staff was reeducated the importance of testing the fire alarm devices on a quarterly basis and providing accurate documentation for verification. 4. The maintenance staffs progress will be reported to the Quality Assurance Committee in March 2011.	03/06/11
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130		

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K 130	Continued From page 4 Based on observations during the Life Safety Code Inspection, it was determined that fire extinguishers in the hallways were not always checked on a monthly basis as required in four (4) of 12 observations . The findings include: Fire extinguisher located in the hallways were not visually checked each month to verify that extinguishers are fully charged during the months of November and December 2010; as evidenced by extinguishers that lacked a date of inspection in November 2010 and December 2010 near rooms 637, 624, 616, 7 East hallway in four (4) of 12 observations between 1:47 PM and 4:00 PM on January 25, 2011.	K 130	1. No resident was negatively affected by this deficient practice. 2. All fire extinguisher were re- checked to verify that they a fully charged. 3. The security staff was re educated on checking the fire extinguisher and providing proper documentation. 4. The Security staffs progress will be reported to the Quality Assurance Committee in March 2011.	03/06/11