DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039 01/19/2011

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

(XS)

COMPLETION

DATE

F 000 INITIAL COMMENTS FOOO

An annual recertification survey was conducted January 11, 2011 through January 19, 2011. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 16 residents based on a census of

77 residents on the first day of survey and 61 supplemental residents. An Immediate Jeopardy at CFR 483.25 (H) (I) and (2) Accidents and Supervision was identified on January 18, 2011 at

3:13PM.

The allegation of removal of the IJ situation was received and verified on January 18, 2011 at 6:05

PM and the Immediate Jeopardy was lifted at this time.

F 159 483.10(cX2)-{5) FACILITY MANAGEMENT OF SS=D PERSONAL FUNDS

F 159

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (cX3)-{8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate

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lfiCiency Slatemenl ending with an asterisk (')denotes a deficiency which the Institution may be excused from correcting providing ills determined that other

.ards 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:S10411 Facility ID: HCFD020030 If continuation sheet Page 1 of 102

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

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B. WING \_

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(X5) COMPLETION DATE

F 159 Continued From page 1

accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section

1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one

(1) of 33 residents listed on the "Trust-Transaction

History" report, it was determined that the facility staff failed to assure that personal funds of residents deposited with the facility were accurately accounted for Resident #4.

The findings include:

A review of Trust-Transaction History report dated January 12, 2011 was conducted and revealed that Resident #4 had a balance of $5,004.94.

F 159

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1. Resident #4 account balance was adjusted to reflect the correct amount at the time of the survey. Resident #FS account was also corrected.

2. All other resident accounts were audited to verify the correct account balance. No other mistakes were found.

3. The Administrator has re-educated the business office staff on safeguarding, managing and accounting for residents personal funds according to CMS guidelines. Business Office Coordinator or designee

will audit monthly each residents personal fund account to assure a full, complete and separate accounting according to generally accepted accounting principle.

4. The Business Office Coordinator will report the finding from this audit to the Quality Assurance committee monthly times three,

March, April and May 2011. 3/6/2011

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

PRINTED: 02118/2011

FORM APPROVED

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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F 159 Continued From page 2

A face-to-face was conducted on January 14, 2011 at approximately 5:30 PM with Employee #13 regarding Resident #4 ' s account balance. He/she stated, "That balance is incorrect. $3826.99

should have been applied to Resident# F5 account. The Guardian sent the check in for him/her

[Resident #F5] and it [the check] was applied to

Resident #4' s account by mistake. The correction to the accounts has been made. "

The facility failed to assure that personal funds of residents deposited with the facility were accurately accounted.

A face-to-face interview was conducted with Employee #13 on January 14, 2011 at approximately 5:30 PM. He/she acknowledged the aforementioned findings.

F 159

F 160 483.10(c)(6) CONVEYANCE OF PERSONAL SS=D FUNDS UPON DEATH

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by: Based on a review of the ''Trial Balance" and staff

interview for one (1) of four (4) closed records, it was determined that facility staff failed to convey Resident #F4's funds within 30 days of death.

The findings include:

F 160

1. Resident #FS account balance was adjusted to reflect the correct amount at the time of the survey. The $220.00 balance was sent

back to SSI.

2. All other resident accounts were audited to verify that their funds had been conveyed with in 30 days oftheir death. No other mistakes were found.

3. The Administrator has re-educated the

business off ice staff on safeguarding, managing and accounting for residents personal funds according to CMS guidelines. The Business Office Coordinator or designee will audit monthly each residents personal

fund account to assure that all expired resident accounts are closed out and conveyed with in

30 days of the residents' death.

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X5) COMPLETION DATE

F 160 Continued From page 3

A review of the ''Trail Balance" dated January 12,

2011 revealed that Resident #F4 had a balance of

$220.00.

A review of the "Action Summary Report" printed January 12, 2011 revealed that Resident #F4 expired on October 12, 2010.

The facility provided the State Agency (SA) with a copy of a check dated October 22, 2010 made out the (funeral home] for $3, 434.35.

A face-to-face was conducted on January 18, 2011 at approximately 3:00PM with Employee #14. He/she stated, " A check was cut for Resident #F4 on October 22, 2010 and provided to the funeral to close out the account. The $220.00 must have come in from SSI after that [October 22, 2010]. We will return the money back to SSI. "

The facility failed to convey the funds for Resident

#F4 within 30 days of his/her death.

A face-to-face interview was conducted with Employee #14 on January 14, 2011 at approximately 5:30 PM. He/she acknowledged the aforementioned findings.

F 161 483.10(c)(7) SURETY BOND- SECURITY OF SS=C PERSONAL FUNDS

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

This REQUIREMENT is not met as evidenced by:

F 160

F 161

4. The Business Office Coordinator will report the finding from this audit to the Quality Assurance committee monthly times three, March, April and May 2011

I 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

(X3) DATE SURVEY COMPLETED

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A \_ BUILDING  B\_ WING | | |  | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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| F 161  F 202  SS=D | Continued From page 4  Based on record review and staff interview, it was determined that facility staff failed to provide surety bond coverage to assure the security of all personal funds of residents deposited with the facility.  The findings include:  On January 11, 2011 at 9:30AM during the Entrance Conference, the State Agency representative requested a copy of the facility ' s Surety Bond and was told that the facility was in the process of obtaining one.  On January 12, 2011 at approximately 1:00 PM a face-to-face interview was conducted with Employee #13 and 14. Employee #13 reiterated that the facility was in the process of obtaining the Surety Bond.  A review of Trust-Transaction History report dated  January 12, 2011 was conducted and revealed that  33 Resident accounts totaled $28,776.29.  Facility staff failed to maintain surety bond in an amount to cover resident funds for the above reviewed dates.  A face-to-face interview was conducted with Employee #13 on January 12, 2011 at approximately 1:00 PM. He/she acknowledged that the facility did not have a Surety Bond in place to assure the security of resident funds.  483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES  When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, | | F 161  F 202 | | | 1. There were no specific resident cited in this deficiency.  2. Although all residents have the potential to be affected by the deficiency, none were cited.  3. The Administrator has re-educated the business office staff on safeguarding, managing and accounting for residents  personal funds according to CMS guidelines. A Surety Bond will be purchased or a  reasonable substitution will be made available in the amount of $75,000.00. The Business Office Coordinator will generate a monthly report to include a resident fund trial balance. The administrator will ensure that the Surety Bond remains at the appropriate level per . accounting funds  4. The Business Office will be responsible for ensuring compliance through the use of the resident fund trial balance. Weekly monitoring will be conducted and results will be reported at the monthly Quality Assurance meeting times three March, April and May 2011. | | 3/6/2011 |

01/19/2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 202 | Continued From page 5  the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one  (1) of 16 sampled residents, it was determined that facility staff failed to document a discharge summary for Resident #14.  The findings include:  Resident #14 was admitted to the facility on November 24, 2010, with a [chief complaint] of [Status Post Blount Trauma].  An interim telephone order dated December 16,  2010 at 10:30 AM directed " May discharge resident home today. "  A review of the nurse ' s note dated December 16,  2010 at 3:00PM revealed, "Resident discharged home this morning per Doctor' s orders. Resident | | F 202 | | | 1. Resident #14 was not negatively affected by this deficient practice.  2. The charts were review for all other discharged residents to assure that a signed physician discharge summary had been completed. If the discharge summery was missing, we will  request one from the resident's physician.  3. The DON or designee will reeducate the Physicians and the license nursing staff on the importance of having the physicians discharge summery present on a discharged residents chart. The DON or designee will audit discharged residents charts for physicians discharge summaries monthly.  4. The DON or designee will report the findings  of this audit at the Quality Assurance Meeting  Monthly times three {March, April and May  2011) | | 3/6/2011 |
| requested discharge. Evaluated by the psychiatrist  on December 13, 2010 and deem fit for discharge. Writer spoke with mother who confirmed resident has a safe place to return to. Physician's Orders received by writer by phone. "  The clinical record lacked evidence of any  documented discharge summary from the physician for Resident #14 who was discharged on December  16, 2010.  A face-to-face interview was conducted with  Employee #4 on January 18, 2011. He/She | | |

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| F 202  F 226  SS=D | Continued From page 6 F 202 acknowledged that the record lacked a physician  discharge summary. The clinical record was  reviewed on January 18. 2011.  483.13(c) DEVELOP/IMPLMENT F226  ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was  determined that facility staff failed to ensure that newly hired staff and agency staff were trained on abuse prior to staff working with residents in two (2) offive (5) employees and two (2) of four (4) agency staff.  The findings include:  The facility's policy entitled: "Prevention of Abuse" Policy No: HR-012, Effective Date: 2/22/2010 stipulated: Procedures: "All new hires will be screened and subject to a background check before hire. All staff will receive annual education on the recognition and prevention of resident abuse ... "  1. Facility staff failed to ensure that newly hired staff completed the screening/training process prior to working in the facility.  A review of Employee #29's file was conducted on January 18, 2011 at approximately 2:00PM in the presence of Employee #2. The employee's | | | | 1. No res1dent was negatively affected by this deficient practice.  2. All nursing center employees, contact or and volunteers that have contact with the nursing center resident were check for abuse and neglect training. Those found not to be In compliance in-serviced Immediately.  3. The administrator or designee will develop a abuse and neglect training module that will be present to all new employees during orientation. Signed documentation of training should be found in each employee's personnel record. The Administrator or designee will audit this process monthly.  4. The Administrator or designee will report the findings of this audit at the Quality Assurance Meeting Monthly times three (March, April and May 2011) | | 3/6/2011 |
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| F 226 | Continued From page 7 file revealed the following:  Date of hire June 23, 2010.  There was no evidence of a " Receipt of Patient/Resident Abuse Policy" in the employee ' s file which indicated that the employee had not received the training 216 days after the date of hire.  The criminal background check was completed on July 7, 2010, 15 days after Employee #29's date of hire.  A face-to-face interview was conducted with  Employee #2 on January18, 2011 at approximately  2:00PM. Employee #2 acknowledged that the employee has not received abuse training up to 86 days after he/she was hired and that the criminal background check was conducted 15 days after the employee was hired.  Facility staff failed to complete the background check and provide education on the recognition and prevention of resident abuse for Employee #29 prior to his/her employment.  2. Facility staff failed to ensure that newly hired staff completed the screening/training process prior to being employed in the facility.  The employee record lacked evidence that Employee #30 received education on the recognition and prevention of resident abuse.  Date of hire October 25, 2010. Date prevention of resident abuse training received January 13, 2011. | | F 226 | | |  | |  |

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X5) COMPLETlON DATE

F 226 Continued From page 8 F226

A face-to-face interview was conducted with

Employee #2 on January18, 2011 at approximately

2:00 PM. Employee #2 acknowledged that the abuse training was not conducted up to 86 days (January 18, 2011) after the date of hire for Employee #30.

Facility staff failed to provide education on the recognition and prevention of resident abuse for Employee #30 prior to his/her employment.

3. Facility staff failed to ensure that Employee #31 received education on the recognition and prevention of resident abuse prior to his/her employment at the facility.

A review of Employee #31's file was conducted on January 18, 2011 at approximately 2:00 PM in the presence of Employee #2. The employee's file revealed the following:

Date of hire October 1, 2010.

There was evidence of a " Receipt of Patient/Resident Abuse Policy" in the employee ' s file. The facility's policy entitled: "Prevention of Abuse" Policy No: HR-012, Effective Date:

2/22/2010 stipulated: Procedures: "All new hires will be screened and subject to a background check before hire. All staff will receive annual education on the recognition and prevention of resident abuse

... " The policy was signed October 15, 2010,

indicating the employee received the training 14 days after he/she began employment with the facility.

A face-to-face interview was conducted with

Employee #2 on January18, 2011 at

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| F 226 | Continued From page 9  approximately 2:00 PM. Employee #2 acknowledged that the abuse training was not conducted up to 14days after the date of hire for Employee #31. | |  | | | | |  |
| F 226 | | |  | |
| Facility staff failed to ensure that Employee #31 received education on the recognition and prevention of resident abuse prior to his/her employment at the facility.  4. Facility staff failed to ensure that Employee #32 received education on the recognition and prevention of resident abuse prior to his/her employment at the facility.  A review of Employee #32's file was conducted on January 18, 2011 at approximately 2:00 PM in the presence of Employee #2. The employee's file revealed the following:  Date of hire November 8, 2010.  There was evidence of a " Receipt of Patient/Resident Abuse Policy" in the employee ' s file. The facility's policy entitled: "Prevention of Abuse" Policy No: HR-012, Effective Date:  2/22/2010 stipulated: Procedures: "All new hires  will be screened and subject to a background check before hire. All staff will receive annual education on the recognition and prevention of resident abuse  ... " The policy was signed December 20, 2010,  indicating the employee received the training 14 days after he/she began employment with the facility.  A face-to-face interview was conducted with  Employee #2 on January18, 2011 at approximately  2:00PM. Employee #2 acknowledged that the | | |
|  | abuse training was not | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED

A BUILDING

095039 B WING 01/19/2011

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

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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION

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TAG

CROSS-REFERENCED TO THE APPROPRIATE DATE

DEFICIENCY)

F 226 Continued From page 10 F 226 conducted up to 73 days after the date of hire for

Employee #31.

Facility staff failed to ensure that Employee #32 received education on the recognition and prevention of resident abuse prior to his/her employment at the facility.

F 250 483.15(g)(1) PROVISION OF MEDICALLY F 250

SS=E RELATED SOCIAL SERVICE 1. A qualified Social Worker was hired and started working on 02/14/2011.

The facility must provide medically-related social Medically - Related social services will be services to attain or maintain the highest practicable provided to assist resident 1111in completing physical, mental, and psychosocial well-being of their application for Social Security. The Social

Worker will also complete the quarterly social

each resident.

services assessment for Resident 1111. Resident

1114 was discharged to the community

12/17/2011. Social Services will provide evidence that resident 1114 was referred to

This REQUIREMENT is not met as evidenced by: Community Connection for discharge. Social worker will evaluate and assist resident IIP1in

discharge planning and medically related social

Based on record review and staff interview for two services. Social worker will evaluate

(2) of 16 sampled and two (2) of 10 supplemental appropriateness and assist resident IISAM2 In

residents, it was determined that facility staff failed discharge planning to go to a mental hea lth to provide medically related social services and group home other medically related social discharge planning to meet residents' needs. services.

Residents #11,14, P1 and SAM2. 2. All other residents were check that may be

affected by this deficient practice and the

Social Worker or designee will assist the

The findings include:

resident with the appropriate medically related social services for compliance If

needed.

1. Facility staff failed to provide medically-related 3. The new Social Worker will be educated on all social services to assist Resident #11 in completing policies and procedure pertaining to socia l his/her application for Social Security. services, updated on pending social service

issues and work on bring the facility back In

Resident #11 was admitted to the facility on compliance with resident social assessments,

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September 11, 2009.

A review was conducted of a letter sent from the

MDS, care plans and handling resident medically related social services needs etc.

Social Security Administration dated May 12, 2010, 4. The Social Worker will report their progress at

second request. The letter was sent to Resident the Quality Assurance meeting monthly.( on

#11 requesting information necessary to going) 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B WING \_ \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  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) | | (X5) COMPLETION DATE |
| F 250 | Continued From page 11  complete his/her application for Medicaid. The letter also stipulated, "It is important that you return the information to us right away so that we can decide if you are eligible. You could lose benefits if you return the information to us after May 24, 2010."  A face-to-face interview was conducted with Resident #11 on January 12, 2011 at 11:30 AM. He/she stated, "I have not spoke with a social worker in months; and I have not had my social security paperwork followed up on."  A review of the clinical record, including the social worker section, revealed that an initial social work assessment was completed [no date indicated]. The record lacked evidence that information was sent to the Social Security Administration to complete the application process. Additionally, there were no ongoing quarterly social service  assessments conducted after the initial assessment  was completed for Resident #11.  A face-to-face interview was conducted with Employee #7 on January 14, 2011 at 3:00PM. He/she acknowledged that there were no social services notes on the resident's clinical record. The record was reviewed on January 14, 2011.  2. Facility staff failed to provide medically-related social services to meet needs for discharging Resident #14.  Physician ' s orders dated and signed November 28,  2010, directed "Please follow up at Community  Connection with [MD].  A psychiatric consultation note dated December 13,  2010 at 12:25 PM included: "...Zyprexia for  Schizophrenia- seeing devil[decreased for -9-10 | | F 250 | | |  | |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 250 | Continued From page 12  months. [Diagnosis] Schizophrenia since 2/10 [February 2010] ... with Community Connections, stays home - apartment with wife... Plan - OK for discharge. Rx- Zyprexia, community connections referral."  An interim telephone order dated December 6, 2010 at [3:18PM] revealed, "Resident to have discharge planning."  There was no evidence that Resident #14 was refereed to Community Connections.  A face-to-face interview was conducted with Employee #2 on January 18, 2011at 12:00 PM. He/She acknowledged that there were no documented social service interventions in the record. The record was reviewed on January 18,  2011.  3. Facility staff failed to provide medically related social services and discharge planning for Resident  #P1.  Review of the information documented in the admission history revealed that the resident was admitted to the facility on December 12, 2010 with diagnoses that included: Thalmic Stroke, Diabetes Mellitus, Lt (Left) Below Knee Amputation, Cholecystitis, Obesity and Rt (Right) Hemiparesis.  A review of the Social Work Section failed to reveal any documentation. Further review of the record failed to reveal any discharge planning documentation.  A face-to-face interview was conducted with | | F 250 | | |  | |  |

OMS NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

SUMMARY STATEMENT OF DEFICIENCIES

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| F 250 | Continued From page 13  Resident P1 at approximately 10:30AM on January  14, 2011. The resident was queried about his/her plans for discharge and whether he/she had spoken to the social worker. He/she stated, " I have not seen a social worker since I was admitted. I am not sure where I will go after discharge. I came from another facility but I do not want to return there and  I do not want to stay here. I hope someone can  help me find a good place. "  A face-to-face interview was conducted with  Employee #2 at approximately 2:00 PM on January  14, 2011. He/she acknowledged that the record lacked social work documentation/intervention. He/she added, "We have not had a social worker for a while but we hired one. He/she will be starting to work soon. However, I have been doing everything I can to meet the residents ' needs. " The record was reviewed on January 14, 2011.  4. Facility staff failed to provide medically related social services and discharge planning for Resident  #SAM2 who was to be discharged to a mental  health group home.  Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included: Diabetes Mellitus, Essential Hypertension, and Osteomyelitis of Right foot.  The resident had previously resided at a Mental Health Group Home prior to requiring acute care and subsequently being admitted to the long term care Facility. | | F 250 | | |  | |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 250  F 251  SS=E | Continued From page 14  Nursing note Dated and signed on December 13,  2010 at 10:30 AM indicated:  " ...resident states: I am going. There will be no more treatment for me. I[am] no longer staying here. "  Psychiatrist Consult note completed December 13,  2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home" Okay to discharge to [mental health group home] home with recommended Medications.  Physician ' s order dated and signed December 13,  2010 at 12:20 PM- Psych. Resident may be disch. [discharged] Home-(self care) Resume Anchor Health Medical Center.  Physician ' s order dated and signed December 15,  2010 at 1910 Discharge to home in the AM. Resident remains in facility as of January 18, 2011.  A review of the Social Work section revealed a social worker note dated and signed November 12,  2010 was titled an introductory note and lacked  documentation of any discharge planning which included the resident being discharged to a mental health group home. This was the only note in the record for the social worker.  A face-to-face interview was conducted with  Employee #2 at approximately 4:30 PM on January  18, 2011. He/she acknowledged that the record lacked documentation of discharge planning by a social worker. The record was reviewed on January  18, 2011.  483.15(g)(2)&(3) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS | | F 250  F 251 | | |  | |  |

OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

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STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) ID I SUMMARY STATEMENT OF DEFICIENCIES

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

TAG OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

I (X5) COMPLETION

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F 251 Continued From page 15

A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals.

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This REQUIREMENT is not met as evidenced by:

Based on staff and resident interview it was determined that the facility failed to employ a qualified social worker on a full-time basis.

A face-to-face interview was held with employee #1 on January 13,2011 approximately 12:00 Noon. When queried about resident concerns involving social work needs, Employee #1 responded "we haven't had a social worker for four (4) to six (6) weeks. We a made an offer to a someone."

Cross reference : 483.15(g)(1) F250 Provision of

Medically Related Social Service

F 253 483.15(h){2) HOUSEKEEPING & MAINTENANCE

SS=D SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

F 251 1

F 253

1. A qualified Social Worker was hired and started to work on 02/14/2011.

2. All resident will be assessed for social services needs and concerns.

*3.* The new Social Worker will be educated on all policies and procedure pertaining to social services, updated on pending social service issues and work on bring the facility back in compliance with resident social assessments, MDS, care plans and handling resident medically related social services needs etc.

4, The Social Worker will report their progress at the Quality Assurance meeting monthly.

(on going) 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

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| F 253 | Continued From page 16  Based on observations made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the facility failed to provide effective maintenance services in residents rooms as confirmed by  accumulated dust noted in two (2) of six (6) resident  's rooms on the sixth floor and seven (7) of seven (7) resident' s rooms on the seventh floor; clutter observed in two (2) of six (6) hallways and in one (1) of seven (7) resident's rooms, a malodorous  scent was detected in one (1) of seven (7) resident's rooms; two (2) of two (2) expired eyewash solution bottles were observed in the soiled utility room on  the seventh floor; a broken wall clock was observed in one (1) of 13 resident's rooms and burnt out bulbs were observed in two (2) of 13 resident 's rooms as well as the spa area located in the beauty shop.  The findings include:  1. Accumulated dust was observed on television sets (rooms #606, 635, 644), on dressers (rooms  #728, 724, 718, 706, 701,758,750), in exhaust vents  (rooms #728, 724, 718, 706, 701, the laundry room on the seventh floor, 750, 758), on table lamps (rooms #706, 750, 635), on the bed frames in room  #706 and window blinds in room #724.  2. The hallway across from the seventh floor laundry room was cluttered with a mattress, three (3) geri -chairs and one (1) scale, and the hallway  by room #644 was filled with items such as three (3)  geri-chairs, one (1) scale, a wheelchair and the walls were marred.  3. Resident room #758 was cluttered with pictures and/or paintings that were stored on the floor in  front of the HVAC unit, a tray table, an electric heater and an extension cord, and the walls were marred. | | F253 1 1. The accumulated dust that was observed on | | | | |  |
|  | | | the television sets (room# 606, 635, 644) on the dressers (Rm#728, 724, 718, 706, 701,  758,750) in the exhaust vents (rm# 728, 724,  718,706,701) the laundry room on the 7'"  floor,(750, 758 )on the table lamps (rm#706,  750, 635), on the bed frames in room#706 and the window blinds in room # 724 was removed.  The hallway across from the seventh floor laundry room that was cluttered with a mattress, three geri-chairs and one scale, and the hallway by room 644 that was filled  with items such as three geri -chairs, one scale, a wheelchair was cleared. The marred walls were repaired.  In resident room# 758, the cluttered pictured and painting that were stored on the floor in front of the HVAC unit was removed. The  tray table, an electric heater, and a extension  cord was also removed. The marred walls were repaired.  The malodorous smell that was evident in room #756 cleaned and removed.  The two bottles of eye wash solution that were expired as of 11/06/10 located in the soiled utility room on the seventh floor were replaced with current solution.  The wall clock that was broken in room #618 was replaced.  The table lamp bulbs that were out in room  #636, 728, and the ceiling light that was also out in the spa area located in the beauty shop was replaced. | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 253  F 272  SS=D | Continued From page 17  4. A malodorous smell was evident in room #756.  5. Two bottles eyewash solution were expired as of 11-6-2010 in the soiled utility room on the seventh floor.  6. The wall clock was broken and needed to be replaced in room #618.  7. Table lamp bulbs were out in rooms# 636, 728 and the ceiling light was also out in the spa area  located in the beauty shop.  These observations were made in the presence of  Employees #1 and #19 who acknowledged these findings during the survey.  483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:  Identification and demographic information; Customary routine;  Cognitive patterns; Communication; Vision;  Mood and behavior patterns;  Psychosocial well-being;  Physical functioning and structural problems;  Continence;  Disease diagnosis and health conditions; Dental and nutritional status;  Skin conditions; Activity pursuit;  Medications; | | F 253 | | | 2. All other resident rooms, hallways and common areas were checked for clutter, burned out light bulbs, dust, odors and marred walls. When these deficient issues were found, they were corrected.  3. The Director of Housekeeping reeducated the staff on keeping the residents rooms and common areas cleaned and dust free (televisions, dressers, exhaust vents, the laundry room, the table lamps, the bed frames and window blinds). The Administrator reeducated the staff on keeping the halls clear of clutter (mattress, geri chairs, scales, wheel chairs etc.). The Nursing staff was reeducated on reporting marred walls, lights that are out, odors, clutter and other facilities issues to maintenance or housekeeping. Management  from Nursing, Maintenance and Housekeeping  or designees will do weekly environmental rounds of the nursing facility to ensure that these deficient practices do not recur.  4. The Director of housekeeping or designee will report the find from the weekly environmental rounds at the Quality Assurance committee meeting Monthly times three March April and May 2011. | | 3/6/2011 |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 272 | 1 Continued From page 18  Special treatments and procedures; Discharge potential;  Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three  (3) of 16 sampled residents, it was determined that facility staff failed to complete admission Minimum Data Set (MDS) assessments/comprehensive assessments for Residents #6, 12 and 15.  The findings include:  According to the Briggs, MDS 3.0 User ' s Manual, Page 2-18 " The Admission assessment is a comprehensive assessment... for a new resident and, under some circumstances a returning resident must be completed by the end of Day 14, counting the date of admission to the nursing home as Day 1. "  1. A review of Resident #6's record revealed that the resident was readmitted to the facility on November 26, 2010 after a hospitalization for respiratory failure. Diagnoses included: Status Post Trach and Chronic Obstructive Pulmonary Disease.  There was no evidence in the resident's record that an admission assessment/comprehensive assessment was completed within 14 days.  A face-to-face interview with Employee #6 was | | F 272 | | | 1. An additional MDS coordinator was hired .The admission/ initial Minimum Data Set (MDS) assessments/ comprehensive assessments for resident #6, 12, and 15 were completed and transmitted to CMS.  2. All other residents were check for completed admission *I* initial MDS assessments/  comprehensive assessments. Those assessments that were not done will be completed and transmitted to CMS according to State and Federal regulations for compliance.  3. The new MDS coordinator will be educated on  all policies and procedures pertaining to the MDS process at the facility. The coordinator will be updated on all pending MDS issues and work towards bring the facility back in to compliance. The MDS coordinator will audit admissions and re-admissions weekly time  two then monthly times three to maintain compliance and to prevent deficient practices from reoccurring.  4. The MDS coordinator will present the findings from this audit to the Quality Assurance Committee monthly (on going) starting March  2011. | | 3/6/2011 |

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| F 272 | Continued From page 19  conducted on January 13. 2010 at 10: 40 AM. He/she acknowledged that the admission MDS was not completed. The record was reviewed January | | F 272 | | |  | |  |
| 13,2011.  2. A review of the clinical record for Resident #12 revealed that the resident was admitted to the facility on November 10, 2010.  A review of the clinical record lacked evidence that an admissions comprehensive assessment for resident#12 was completed within 14 days.  A face-to-face interview was conducted with  Employee #6 and Employee #3 on January 14,  2010 at approximately 12:30 PM. Both acknowledged that admissions comprehensive assessment was not completed and was not in the clinical record. The record was reviewed on January 14, 2011.  3. Facility staff failed to complete admission MDS assessment for Resident #15 within 14 days as indicated by the MDS User ' s manual.  Resident #15 was admitted to the facility on September 20, 2010 and discharged from the facility on November 19, 2010.  A review of the resident ' s closed record failed to reveal an admission MDS.  A face-to-face interview was conducted with  Employee #6 at approximately 11:OOAM on January  18, 2011. He/she acknowledged that the record lacked a completed admission MDS. He/she stated, " The MDS was opened in October and completed in January but was not transmitted. " The employee continued, "We | |  | | |

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| F 272  F 275  SS=D | Continued From page 20  experienced difficulty in completing many of them (MOSes) because we were without an MDS coordinator. I am trying my best to complete all of them but I am also trying to complete the new ones on time. " The record was reviewed on January 14,  2011.  Facility staff failed to complete an initial Minimum  Data Set (MDS) assessment for Resident #15.  483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS  A facility must conduct a comprehensive assessment of a resident not less than once every  12 months.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one  (1) of 16 sampled residents, it was determined, that facility staff failed to complete the annual comprehensive assessment within the regulatory time frames. Resident #8.  The findings include:  Facility staff failed to complete an annual Minimum Data Set (MDS) assessment within 366 of the last [annual] comprehensive assessment for Resident  #8.  According to Briggs MDS User's Guide 3.0 page  2-17, "Comprehensive assessments are completed upon admission, annually and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment has occurred.  A review of the resident's clinical record revealed documentation of an admission comprehensive assessment dated December 30, 2009 and three (3) quarterly assessments dated March 17, 2010, | | F272 | | |  | | 1  3/6/2011 |
| F 275 | | | 1. An additional MDS coordinator was hired. The annual Minimum Data Set (MDS) comprehensive assessment was completed on resident #8.  2. All other residents were check for completed annual MDS comprehensive assessments. Those assessments that were not done will be completed and transmitted to CMS according to State and Federal regulations for compliance.  3. The new MDS coordinator will be educated on all policies and procedures pertaining to the  MDS process at the facility. The coordinator will be updating all pending MDS issues and work towards bring the facility back in to compliance. The MDS coordinator will audit annual comprehensive assessments weekly time two then monthly times three to maintain compliance to prevent this deficient practices from reoccurring.  4. The MDS coordinator will present the findings from this audit to the Quality Assurance Committee monthly (on going) starting March  2011. | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX  OR LSC IDENTIFYING INFORMATION) TAG | | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 275  F 276  SS=E | Continued From page 21  June 18, 2010 and September 28, 2010. No other assessments were located on the resident's records or given to the surveyor by the facility.  A face-to-face interview was conducted with  Employee #6 at approximately 11:OOAM on January  18, 2011. He/she acknowledged that the record lacked a completed annual MDS. for December  2010. He/she stated, "We experienced difficulty in  completing many of them (MDS(s)) because we were without an MDS coordinator. I am trying my best to complete all of them but I am also trying to complete the new ones on time. " The record was reviewed on January 12, 2011.  Facility staff failed to complete the annual comprehensive assessment within the regulatory timeframes for Resident #8.  483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of four  (4) sampled residents and four (4) supplemental residents, it was determined that facility staff failed to assess residents using the quarterly review instrument not less than once every three (3) months. Residents#2, 9, 11, 16, E1, F1, F2, and F3.  The findings include:  1. Facility staff failed to complete a quarterly MDS  for Resident #2. | | F 275  F 276 | | | 1. | |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B. WING \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 276 Continued From page 22

The findings include:

A review of Resident #2's record revealed that a quarterly MDS [Minimum Data Set] was not completed for December 2010. The following MDS assessments were in the record with the following completion dates:

F 276

1. An additional MDS coordinator was hired. The quarterly Minimum Data Set {MDS) comprehensive assessment were completed on residents# 2, 9,11,16, E1, Fl, F2, and F3.

2. All other residents were check for completed quarterly MDS comprehensive assessments. Those assessments that were not done will be

completed and transmitted to CMS according

Quarterly MDS ---­

September 14, 2010

to State and Federal regulations for

Readmission MDS - June 8, 2010

j There was no MDS assessment after September

14, 2010.

According to the "Briggs MDS 3.0 User's Manual

3.0", page 2 -30, "At a minimum, three Quarterly assessments be completed in each 12-month period. The ARD [Assessment Reference Date] must be within 92 days after the ARD of the previous OBRA [Omnibus Budget Reconciliation Act] assessment (i.e., Quarterly, Admission, or Annual assessment+ 92 calendar days). The MDS completion date (Item 205008) must be no later than 14 days after the ARD.

A face-to-face interview with Employee #6 was conducted on January 12, 2011 at approximately

1:40 PM. He/She acknowledged that the quarterly MDS was not present in the record. The record was reviewed on January 12, 2011.

2. Facility staff failed to complete a quarterly MDS (Minimum Data Set) for not less than once every three (3) months for Resident #9.

Review of the clinical record revealed that a quarterly MDS was placed in the record, with

compliance.

3. The new MDS coordinator will be educated on all policies and procedures pertaining to the MDS process at the facility. The coordinator will be updating all pending MDS issues and work towards bring the facility back in to compliance. The MDS coordinator will audit quarterly comprehensive assessments weekly time two then monthly times three to maintain compliance to prevent this

deficient practices from reoccurring.

4. The MDS coordinator will present the findings from this audit to the Quality Assurance Committee monthly (on going) starting March

2011.

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| F 276 | | Continued From page 23  hand written data indicating 02 (quarterly), ARD (Assessment Reference Data) November 1, 2010 completed by November 5, 2010. The quarterly report also revealed that Section C: Cognitive Patterns and Section D: Mood was the only sections that contained handwritten data and no signatures  in Section Z: Assessment Administration.  A face-to-face interview was conducted with Employee #6 on January 12, 2011 at 11:30 AM. After review of the quarterly report he/she acknowledged that the report was opened and in progress.  Facility staff failed to complete a quarterly MDS (Minimum Data Set) for not less than once every three (3) months for Resident #9. The record was reviewed on January 11, 2011.  3. Facility staff failed to complete a quarterly  Minimum Data Set assessment for Resident #11.  A review of the clinical record for Resident #11 revealed that the resident had an annual assessment completed September 22, 2010. There were no additional MDS assessments in the active clinical record.  The clinical record lacked evidence that a quarterly assessment for December 2010 was completed.  A face-to-face interview was conducted with  Employee #6 on January 19, 2011 at approximately  10:00 AM. He/she acknowledged that the quarterly assessment was not completed | | F 276 | | | 1 | |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 276 | Continued From page 24  for December 2010. The record was reviewed  January 19, 2011.  4. Facility staff failed to complete a quarterly  Minimum Data Set assessment for Resident #16.  A review of the clinical record for Resident #16 revealed that the resident had an admission assessment completed August 26, 2010. There were no additional MDS assessments in the active clinical record.  The clinical record lacked evidence that a quarterly assessment for November 2010 was completed.  A face-to-face interview was conducted with  Employee #6 on January 19, 2011 at approximately  10:00 AM. He/she acknowledged that the quarterly assessment was not completed for December 2010. The record was reviewed January 19, 2011.  5. Facility staff failed to complete a quarterly MDS  assessment for Resident #E1.  A review of Resident #E1's record revealed that a quarterly MDS was not completed for December  2010. The following MDS assessments were in the  record with the following completion dates:  Quarterly MDS June 8, 2010  Quarterly MDS September 10, 2010  There was no MDS assessment after September  10, 2010.  According to the Briggs "MDS 3.0 User's Manual" , page 2 -30, "At a minimum, three quarterly | | F 276 | | |  | |  |

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|  |  | |
| F 276 | Continued From page 25  assessments and one comprehensive assessment are required in each 12-month period.  A face-to-face interview with Employee #6 was conducted on January 14, 2011 at approximately  1:40 PM. He/She acknowledged that the quarterly MDS was not present in the record. The record was reviewed on January 14, 2011.  6. Facility staff failed to complete a quarterly  Minimum Data Set assessment for Resident #F1.  A review of the clinical record for Resident #F1 revealed that the resident had an admission assessment completed August 25, 2010. There were no additional MDS assessments in the active clinical record.  The clinical record lacked evidence that a quarterly assessment for November 2010 was completed.  A face-to-face interview was conducted with  Employee #6 on January 19, 2011 at approximately  9:00AM. He/she acknowledged that the quarterly assessment was not completed for November 2010. The record was reviewed January 19, 2011.  7. Facility staff failed to complete a quarterly  Minimum Data Set assessment for Resident #F2.  A review of the clinical record for Resident #F2 . revealed that the resident had an annual | | F 276 | | |  | |  |

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| F 276  F 278  SS=D | Continued From page 26  assessment completed July 28, 2010. There were no additional MDS assessments in the active clinical record.  The clinical record lacked evidence that a quarterly assessment for October 2010 was completed.  A face-to-face interview was conducted with  Employee #6 on January 19, 2011 at approximately  9:30AM. He/she acknowledged that the quarterly assessment was not completed for October 2010. The record was reviewed January 19, 2011.  8. Facility staff failed to complete a quarterly  Minimum Data Set assessment for Resident #F3.  A review of the clinical record for Resident #F3 revealed that the resident had a quarterly assessment completed August 15, 2010. There were no additional completed OBRA MDS assessments in the active clinical record.  The clinical record lacked evidence that a quarterly assessment for November 2010 was completed.  A face-to-face interview was conducted with  Employee #6 on January 19, 2011 at approximately  9:00AM. He/she acknowledged that the quarterly assessment was not completed for January 2011. The record was reviewed January 19, 2011.  483.20(g) - U) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the | | F 276  F 278 | | |  | |  |

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| F 278 | Continued From page 27  resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for two (2) of 16 sampled residents, it was determined that facility staff failed to code the Minimum Data Set [MDS] for: the use of antipsychotic medications for one (1) resident and allergy for one (1) resident. Residents #3 and #7.  The findings include:  1. Facility staff failed to code the quarterly MDS | | F 278 1 1. An additional MDS coordinator was hired. The | | | | |  |
|  | | | quarterly Minimum Data Set (MDS) comprehensive assessment was coded for antipsychotic medications for resident# 3. The quarterly Minimum Data Set (MDS) comprehensive assessment was coded for "allergy" under Section !{Additional Active Diagnosis) for Resident #7.  2. All other residents were check for completed quarterly MDS comprehensive assessments codes. Those assessments codes that were not done will be completed and transmitted to CMS according to State and Federal  regulations for compliance.  3. The new MDS coordinator will be educated on all policies and procedures pertaining to the MDS process at the facility. The coordinator will be updating all pending MDS issues and work towards bring the facility back in to compliance. The MDS coordinator will audit annual comprehensive assessments weekly time two then monthly times three to  maintain compliance to prevent this deficient practices from reoccurring.  4. The MDS coordinator will present the findings from this audit to the Quality Assurance Committee monthly (on going) starting March  2011. | |
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| F 278 | Continued From page 28  3.0 completed January 12, 2011 for "antipsychotic  " medications Resident #3.  A review of the Physician ' s Order Sheets dated December 30, 2010 directed, "Risperidone 1 mg via G-tube daily for agitation "  A review of the Medication Administration Record  for January, 2011 revealed that the order " Risperidone 1mg via G-tube daily for agitation " was administer daily through January 12, 2011.  A review of the quarterly MDS 3.0 dated January12,  2011 revealed that Section N0400 [Medications received] was not coded for "Antipsychotic".  The facility failed to code for Antipsychotic on the quarterly MDS 3.0 completed January 12, 2011. A face-to-face interview was conducted with  Employees# 6 and ?on January 12, 2011 at 9:00  AM. They acknowledged that "Antipsychotic" was not coded on the admission MDS 3.0. The record was reviewed January 12, 2011.  2. Facility staff failed to code the Admissions MDS | | F 278 | | |  | |  |
|  | 3.0 dated December 28, 2010 for "Allergy" under  Section I [Additional Active Diagnosis] for Resident  #7.  A review of the Physician Order Sheet and Plan of Care dated December 24, 2010 the section " allergy history " list resident allergy as, " Keppra " A review of the Interim ' s Order Form dated November 30, 2010 in the allergies section also listed resident allergy as, "Keppra"  A review of the admission MDS 3.0 with a completion date of December 28, 2010 revealed that "Allergy" was not coded in Section I 1800 [Additional Active Diagnosis].  A face-to-face interview was conducted with  Employees #6 and #7 on January13, 2011 at 9:00  AM. After review of the documents both | |
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| F 278 | Continued From page 29  acknowledged that "Allergy" was not coded on the admission MDS 3.0.  Facility staff failed to code the Admissions MDS for  "allergies". The record was reviewed January 13,  2011. | | F 278  F 279 | | |  | |  |
|  | | |
| F 279  SS=E | 483.20(d), 483.20(k)(1) DEVELOP  COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10,  including the right to refuse treatment under  §483.1O(b)(4).  This REQUIREMENT is not met as evidenced by: Based on Record review and staff interview of four  (4) of 16 sampled residents and one (1) | |
| supplemental resident, it was determined that  facility staff failed to develop a care plan for three  (3) residents for nine (9) or more meds, one (1) I  resident for anticoagulants, and one (1) resident for  allergies and CPAP [Continuous Positive | | | | |

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X5) COMPLETION DATE

F 279 I Continued From page 30

Airway Pressure]. Residents #5, #7, #8, #12 and

#E1.

The findings include:

1. Facility staff failed to develop a care plan for

Resident #5 for the use of multiple anticoagulants.

Review of the "Admission Order Sheet and Physician Plan of Care dated and signed by the physician on November 9, 2010 revealed that the resident was admitted with a Diagnosis of Atrial Fibrillation, CHF (Congestive Heart Failure, Accelerated HTN (Hypertension), Renal Failure, History of gout, History of Cerebral Aneurysmectomy S/P (status post) G-tube placement. "

Review of the (MAR) Medication Administration Record for the month of December 2010 revealed that Resident #5 was receiving "Aspirin Chewable tab 81 mg once daily for CVA (Cerebral Vascular Accident) and Lovenox injection 60 mg Subcutaneous every day for prophylaxis.

Review of the care plans last updated January 6,

2011 failed to identify a care plan with goals and approaches for the use of multiple anticoagulants.

A face-to-face interview was conducted with Employee #2 on January 11, 2010 at 11:30 AM. After review of the above he/she acknowledged the findings.

Facility staff failed to develop a care plan for Resident #5 for the use of multiple anticoagulants. The record was reviewed on

F 279

1. The Inter Disciplinary Team (lOT) wlll develop a Care Plan 'for Resident tiS for the use of multiple anticoagulants. The lOT will initiate a care plan for the potential drug interaction for the use of nine or more medications for Resident 117. The IDT will develop a care plan will for potential adverse drug interactions

with the use of nine or more medications for residents #8 The IDTwlll initiate a care plan for the potential drug Interaction for the use

of nine or more med1cations for Resident 1112.

The FaciHty will initiate a care plan with appropriate goa ls and approaches for

Resident II £1 who Is on C-PAP. The Facility wll

initiate a care plan with appropria te goals and approaches for allergies Peniclllln and Llsinopril for Resident II El.

2. All other residents were check that may be

affected be this deficient practice and the appropriate care plan will be developed for compliance if needed.

3. The DON or designee will reeducate the lOT

members on reviewmg and revising the comprehensive care plans developed for each resident to include measurable objectives and timetables to meet the residents' medical,nursing and mental psychosocial needs that are identified in a comprehensive assessment. The clinical

manager will monrtor this process monthly on admission and readmission and quarterly to assure that all resident care plans *are* done and updated as scheduled.

4. Result from this monitoring will be reported at the Qualtty Assurance meeting monthly. (On going). Any additional issues or concern will be

addressed at this meeting. 3/6/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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095039 01/19/2011

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(X5) COMPlETION DATE

F 279 Continued From page 31

January 11, 2011

2. Facility staff failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #7.

A review of the January, 2011 physician ' s orders

signed December 30, 2010 directed, "Ativan, Aspirin, Norvasc, lovenox, Metoclopramide, Prednisone, multivitamin, Ranitidine, Benadryl, Trileptal, Simvastatin, Acular, Lumigan and Alphagan. "

A review of the plan of care on January 12, 2011 for Resident #7 lacked documented evidence that facility staff developed a care plan with goals and approaches for the potential drug interactions for

the use of nine (9) or more medications.

A face-to-face interview was conducted on January13, 2011 at approximately 12:21 PM with Employees #7 and #9. They acknowledged that a care plan for the use of nine (9) or more medications was not initiated. The record was reviewed January 12, 2011.

3. Facility staff failed to develop a care plan for potential adverse drug interactions with the use of nine (9) or more medications for Resident #8.

F 279

A review of the clinical record for Resident #8 revealed a physician ' s order dated and signed December 30, 2010 that included the following medications: K-Dur, Lactulose, Lexapro, Mirtazepine, Morphine ER, Nizatidine, Ditropan, Senna, Acetaminophen, Abillify and Amantadine. The Physician ' s Order Sheet (POS) revealed that all of the medications were initially ordered on September 23, 2010.

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|  | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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| F 279 | | Continued From page 32  A review of the care plan that was last updated on September 30, 2010 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications.  A face-to-face interview was conducted with Employee #7 at approximately 11:OOAM on January 18, 2011 He/she looked at the care plans and acknowledged the finding.  Facility staff failed to develop a care plan with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications for Resident #8. The record was reviewed on January 12, 2011.  4. Facility staff failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #12.  A review of the January 2011 physician's orders signed December 30, 2010 directed, "Trazadone, Folic Acid, Zocor, Thiamine, Lisinopril, Hydrochlorothiazide, Senna, Colace, Seroquel, Miralax, Multivitamin and Tylenol."  A review on January 14, 2011 of the plan of care for Resident #12 lacked documented evidence that facility staff developed a care plan with goals and approaches for the potential drug interactions for the use of nine (9) or more medications.  A face-to-face interview was conducted on January  14, 2011 at 1:21 PM with Employee #3. He/she acknowledged that a care plan for the use of nine (9) or more medications was not initiated. | | F 279 | | | f | |  |

SUMMARY STATEMENT OF DEFICIENCIES ID

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 279 | Continued From page 33  The record was reviewed on January 14, 2011  5A. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident  #E1, who was on C-PAP [Continuous Positive  Airway Pressure].  A review of a pulmonary consult dated and signed  July 22, 2010 revealed, "Use CPAP with sleep at  12 em H20 pressure. "  A review of Resident #E1's record revealed a physician's order dated July 22, 2010, directing, "Use C-PAP with sleep at 12 em H20."  The care plan, last reviewed September 9, 2010, was not updated to include appropriate goals and approaches for the use of a C-PAP machine.  A face-to-face interview was conducted with Employee #7 on January 14, 2011 at 10:00 AM. He/she acknowledged that there should have been a care plan for the use of the CPAP machine. The record was reviewed July 14, 2011.  58. Facility staff failed to initiate a care plan with appropriate goals and approaches for allergies to Penicillins and Lisinopril for Resident #E1.  The physician's note dated August 27, 2010 revealed, "Allergy- PCN [Penicillin] and Lisinopril." A review of the November and January 2011  Physician ' s Order sheet, signed by the physician on December 29, 2010 and January 12, 2011 revealed, " Allergies: Penicillins, Lisinopril. "  The Medication Administration Record [MAR] for  July 2010 revealed, "Allergies: Penicillins, | | F 279 | | |  | |  |
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OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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WASHINGTON, DC 20032

01/19/2011

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SUMMARY STATEMENT OF DEFICIENCIES

ID PROVIDER'S PLAN OF CORRECTION

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F 279 Continued From page 34

Lisinopril. "

The resident' scare plan initiated December 2,

2009, last updated September 9, 2010 lacked evidence that a care plan with- goals and

approaches was developed to address the resident ' s allergies.

A face-to-face interview was conducted on January

14, 2011 at approximately 2:00 PM with Employee

#7. He/she acknowledged that there was no care plan for allergies for Resident #E1. The record was reviewed on January 14, 2011.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for two (2)

of 16 sampled residents, it was determined that facility staff failed to provide Trach care according to accepted standards of clinical practice. Residents

#2 and #3.

The findings include:

1. Facility staff failed to maintain aseptic technique prior to Trach care for Resident #2.

Employee #10 was observed on January 12, 2011 at approximately 2:25 PM performing Trach care to Resident #2. During preparation for Trach care, Employee #10 opened one sterile catheter kit and created his/her sterile field. Employee #10 then proceeded to remove a previously opened catheter kit tray with a suction catheter exposed

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F 279

F 281

DEFICIENCY)

1. The licensed Nurse that failed to provide tracheal suctioning according to accepted standards of clinical practice for residents #2 and 3 were reprimanded and reeducated on correcting that deficient practice.

2. All other licensed Nursing Staff that may do

trach care were reeducated on providing tracheal suctioning care.

3. All licensed staff will be given an in service relating to Tracheotomy Care to include Policies on "Suctioning a Tracheotomy Tube and Tracheotomy Care" by the DON or designee. A Competency Validation Tool on Critical Elements for Suctioning will be used. The goal is that all RN/LPN will demonstrate knowledge and skill in suctioning and tracheotomy. Must meet all the critical elements of the procedure and will be checked randomly by the unit manager and nursing

supervisors weekly for 3 months until each licensed can demonstrate the procedure times five.

4. Findings from these random checks will be

presented to the Quality Assurance Committee

Monthly starting March 2011. 3/6/2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281 | Continued From page 35  from Resident #2' s bedside table. He/she then removed the suction catheter from the previously open tray and placed it on the sterile field. At this point the sterile field was contaminated.  Employee #10 failed to maintain sterile technique during preparation for Trach care.  According to the " 2007 Lippincott ' s Nursing Manual " , under Tracheostomy Care Procedure " revealed for sterile tracheobronchial suction by way of tracheostomy .... Equipment ...assemble the following equipment or obtain a prepackaged  suctioning kit: Sterile suction catheters ... " | | F 281 | | |  | |  |
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|  | Facility staff failed to maintain sterile technique prior  to Trach care.  A face-to-face interview was conducted on January  12, 2011 at 2:25PM with Employees #3 and #4. They acknowledged that Employee #10 should have used a new prepackaged sterile suction kit with a catheter in preparing for Resident #2 ' s Trach care.  2. Facility staff failed to provide Trach care according to accepted standards of clinical practice during Trach care observation for Resident #3.  On January 14, 2011 at 9:30AM during Trach care  observation Employee#22 washed his/her hands and pulled out a suction care kit out of resident #3 ' s bedside drawer that consisted of sterile gloves, container for normal saline and suction catheter. He/she then don blue clean gloves on, open sterile packet pull sterile suction catheter out of bag, connected suction catheter to | |
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OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X5) COMPLETION DATE

F 281 Continued From page 36

suction tubing and ask resident to hold the suction tubing with the sterile suction catheter attached to it. He/she then removed the blue clean gloves and placed them in garbage bag then without washing his /her hands removed sterile gloves from its container and put them on. He/she opened up the normal saline bottle and poured the saline solution

in the sterile container then took suction tubing with

the sterile catheter attached back from resident and proceeded with suctioning resident Trach. After Trach suctioning she voiced that the Trach care was already done by respiratory. He/she removed all used supply and placed them in garbage bag then cleaned resident table discard trash in biohazard container in soiled utility room and then he/she washed hands.

During observation facility staff failed to use "

Professional Standard of Quality " to suction Trach during Trach care.

"Wash hands with antimicrobial soap. Opens equipment and sets up sterile field. Fill the two basins provided in kit with Normal Saline or sterile water. Dons face mask, gown, and goggles (if splashing is anticipated). Dons sterile gloves provided in suction catheter kit. Designate one hand as contaminated for disconnecting, bagging, and working the suction control. Usually the dominant hand is kept sterile and will be used to thread the suction catheter. Use the sterile hand to remove carefully the suction catheter from the package, curling the catheter around the gloves fingers. Connect suction source to the suction fitting of the catheter with the contaminated hand. Using contaminated hand disconnect the resident from the ventilator. Suction inner cannula. Gently insert suction catheter as far as possible into the artificial airway without applying suction, withdraw catheter 2 to 3cm and apply suction. Quickly

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| F 281  F 309  SS=E | Continued From page 37  rotate the catheter while it is being withdrawn. Limit suction time to no more than 10 seconds. Instill  3-5ml sterile normal saline into the artificial airway during spontaneous inspiration if secretions are tenacious. Rinse catheter between suction passes by inserting tip in cup of sterile water and applying suction. Continue making suction passes, bagging the resident between passes, until the airways are clear of accumulated secretions. Give the patient four to five " sigh " breaths with ambu bag. Return the resident to ventilator. "  Tracheostomy Care Procedure, Fundamentals of Nursing Made Incredibly Easy (2007) Lippincott [www.sh.lsuhsc.edu/policies/policy\_manuals\_via\_ms](http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms)  \_word/Nursing/T-25.pdf  [<http://www.sh.lsuhsc.edu/policies/policy\_manuals\_](http://www.sh.lsuhsc.edu/policies/policy_manuals_)  via\_ms\_word/Nursing/T-25.pdf>  A face-to-face interview was conducted on January  14, 2011 at 9:40AM with Employee #7 Employee#  9 and Employee #22. They acknowledged that the suctioning of the Trach was not provided according to professional standard of practice. The record was reviewed on January 14, 2011.  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance· with the | | F 281  F 309 | | |  | |  |
| 1. No resident was negatively affected by this deficient practice. Resident #2, 5 an 6 were  weighed according to the Physicians Orders.  2. All other resident were checked that may be affected by this deficient practice to assure that their weights have be taken according to the Physicians order. Those that were found to be out of compliance were weighed. | |  |
| comprehensive assessment and plan of care. | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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01/19/2011

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DEFICIENCY)

F 309 Continued From page 38

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview of four (4) of 16 sampled residents and one (1) supplemental resident it was determined that facility staff failed to follow physician ' s orders for monthly weights for one (1) resident. weekly weights for two (2) residents, one (1) supplemental resident receiving hypertensive medications with

parameters, and one (1) resident receiving Phenobarbital, and failed to assess one (1) resident prior to administration of pain medications and failed to indicate when to administer either Percocet one (1) tablet or Percocet two (2) tablets. Residents #2,

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5, 6, 11, and E2.

The findings include:

1. Facility staff failed to follow physician's orders for to obtain monthly weights for Resident #2.

A review of Resident #2 ' s record revealed

physician ' s orders signed and dated December 19,

2010, originated May 26, 2010 directed, "Weights

Monthly."

A review of Resident #2 ' s record revealed the following weights for 2010:

July 2010- no weight documented

August 2010 - 176.5 pounds

September 2010- no weight documented

October 2010-179 pounds

November 2010- 176 pounds

There was no evidence in the record that the resident had consistent monthly weights.

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F 309 3. The DON has in serviced all nursing staff on the weight policy and using the weight monitoring log. All residents monthly and weekly weights

will be monitored by the Unit Manager and the Charge Nurses. The Monthly and /or weekly weight variance report is discussed in the weekly risk meeting. A weight monitoring log has been developed to record weights taken

on admission audited weekly.

A controlled substance procedure to oversee C2-CS medications has been developed. An Emergency Narcotic Box has been put in placed to assure C2 medications are being given as ordered by the physician. An in service was conducted by the Pharmacist for the licensed nursing staff. C2-CS oversight training has been incorporated as part ofthe

nurse orientation. The DON or designee will be auditing the controlled substance procedure weekly.

4. Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May

2011. 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 309 | | Continued From page 39  A face-to-face interview was conducted with  Employees #3 and Employee #21 on January 12,  2011 at approximately 1:30 PM. Both acknowledged that monthly weights were not consistently done in accordance with the physician ' s orders. The clinical record was reviewed on January 12,2011.  2. Facility staff failed to perform weekly weights x4 (times four) according to the physician's admissions orders for Resident #5.  A review of the "Admission Order Sheet and Physician Plan of Care" signed and dated November 9, 2010 revealed the following diagnoses: " Fib (Atrial Fibrillation), CHF (Congestive Heart Failure), Accelerated HTN (Hypertension), Renal Failure, Hx (history) of Gout, History of Cerebral Aneurysmectomy, S/P (status post) G-tube (Gastrostomy tube) placement; Treatment: " ... (2) Weight weekly x4 (times four) then monthly and PRN ... "  A review of the " Resident Monthly Weight Record " revealed that the resident had an Admissions  weight of 150.3 pounds.  The record failed to identify weekly weights x4 (times four (4)) after admissions.  Further review of the facility's "Weights and Vitals  Summary " identified the resident weight in  November 2010 as 150.3 pounds.  The summary failed to identify weekly weights times four (4) after admissions.  A face-to-face interview was conducted with  Employees #20 and Employee #21 on January 13,  2011 at 11:30 AM, a query was made as to when weights are performed and what is the process for reweighing a resident? Employee #21 indicated that "weights are due the 5th of | | F 309 | | | 3B  1. Resident# 6 was not negatively affected by the deficient practice.  2. All other resident were checked that may be affected by this deficient practice if their medication was found not to available at that it was immediately ordered from the pharmacy.  3. A controlled substance procedure to overview  C2-CS medications has been developed. An Emergency Narcotic Box has been in placed to ensure C2 medications are being given as ordered by the physician. An in service was conducted by the Pharmacist to the LPN/RN and C2-CS overview is part of the new employee orientation. The DON or designee will be auditing the controlled substance procedure weekly.  4. Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May  2011 | |  |

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OMS NO 0938-0391

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| F 309 | Continued From page 40  every month, if there is a significant change increase or decrease then reweights will be requested. "  A review of the facilities policy "Resident Weight  and Weight Changes" Policy Number Diet SS-815 revealed (2) Each resident will be weighed monthly (every 30 days) or more frequently (weekly, daily) per physician ' s order, nursing, or dietitian recommendation. "  The facility staff failed to perform weekly weights  according to the physician ' s orders for Resident  #5. The record was reviewed on January 13, 2011.  3A. A review of Resident# 6's record revealed physician' s orders signed and dated for January  12, 2011, originated November 27, 2010 directed,  'Weight weekly X4 [times four] then monthly and as needed."  The "Treatment Administration Records"  indicated the following weights:  November 26, 2010 (Hour 3-11)- 138.1 pounds December 3, 2010 (Hour 3-11) -143.6 pounds There was no evidence in the record that the resident had weekly weights times four (4) as directed by the physician's order since December 3,  2010.  A face-to-face interview was conducted with Employee #7 on January 13, 2011 at 11:30 AM. He/she acknowledged that weekly weights were not done in accordance with the physician ' s orders.  3B. Facility failed to administer Phenobarbital in accordance to physician ' s order for Resident #6.  According to the " Physician Order Sheet and | | F 309 | | |  | |  |
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| F 309 | Continued From page 41  Plan of Care" signed and dated November 27,  2010 directed, " Phenobarbital 50mg via GT [gastrostomy tube] twice daily for seizure disorder. "  A review of the November Medication  Administration Record revealed the following:  Phenobarbital 50 mg via G-T was circled in designated boxes indicating medication not administered on November 27 and 28, 2010 at 9:00  AM and 5:30PM, November 29, and 30, 2010 at  5:30PM.  According to the Medication Administration Record the reasons stated for medications not administered revealed the following:  November 27, 2010 at 9:00AM and 5:30PM  ....Phenobarbital on order .... Not given. November 28, 2010 (not time indicated)­ Phenobarbital 50mg on order---- not given November 29, 2010 at 5:30 PM - Phenobarbital  50mg---not available---Pharmacy notified. November 29, 2010 (no time indicated)­ Phenobarbital 50mg not available - Pharmacy | | F 309 | | |  | |  |
| notified. | | |
|  | A review of the nurse's note dated November 29,  2010 at 10:00 PM revealed, "Resident alert and stable, assisted with care, G-tube intact and patent, tolerated feeding well, Trach care done, suctioned as needed. Phenobarbital 50mg not given on this shift, not available, pharmacist was notified, MD need to sign C2 Form. MD [Medical Doctor] notified at 6:30 PM. [Medical Doctor] said he/she will sign C2 form in AM." | |

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| (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | COMPLETION  DATE |
| F 309 | Continued From page 42  There was no evidence in the record that the Phenobarbital was administered in accordance with the physician's orders until November 30, 2010 at  9:00AM.  A face-to-face interview with Employees #4 and #7 was conducted on January 13, 2011 at approximately 2:00PM. Both acknowledged after reviewing the clinical record, that there was no evidence in the record indicating Phenobarbital was administered according to the physician ' s orders. Employee #2 stated, "Since that occurrence, a controlled substance procedure to overview for  C2-C5 medications " have been developed to ensure C2 medications are being given as ordered by the physician. The clinical record was reviewed on January 13, 2011.  4. Facility staff failed to clarify the medication orders for the use of Percocet one (1) or two (2) for tabs. Resident #11.  The physician ' s order dated January 2011 and signed by the physician on January 6, 2011 directed, " Oxycod/APAP tab 7.5/325 take two  tablets by mouth every 4 hours as needed for pain. "  The physician ' s order dated January 2011 and signed by the physician on January 6, 2011 directed, " Oxycod/APAP tab 7.5/325 take one tablet by mouth every 4 hours as needed for pain. " A review of the Medication Administration Record for January 2011 revealed that Resident #11 received Oxycod/APAP tab 7.5/325 two tablets by  mouth every 4 hours as needed for pain on January  3, 4, 5 and 7, 2011 and Oxycod/APAP tab 7.5/325 one tablet every 4 hours on January 1, 2, 3, 4, 5, 6,  7, 8, 9, 10, 11, 12, and 13,2011.  A review of the back of the MAR revealed that | | F 309 | | | 1 | |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER!SUPPLIER!CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B.WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE  OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | | | | | | (X5) COMPLETION DATE |
| F 309 | Continued From page 43  when the medication was administered on the aforementioned dates the reason was for pain. When the medication was administered there were no indications to direct the nursing staff to administer one or two tablets of Oxycod/APAP  7.5/325 for pain. Additionally, there was no  evidence that the "Pain Assessment Tool" was used to assess the resident ' s level of pain.  A face-to-face interview was conducted with  Employee #7 on January 18, 2011 at approximately  3:00 PM. He/she acknowledged that there were no indications directing the nursing staff when to administer one or two tablets of Oxycod/APAP  7.5/325 for pain. The record was reviewed January  18, 2011.  5. Facility staff failed to follow physician ' s blood pressure parameters prior to administering Lisinopril to Resident #E2.  According to a " Physician Progress Note " dated and signed on May 31, 2010 revealed, " Present Illness: Cerebral Vascular Accident, Hypertension, and Depression. "  A review of the " Physician ' s Order " dated and signed November 30, 2010 directed, " Lisinopril Tablet 40mg by mouth daily - Hold for systolic blood pressure less than 110 or diastolic blood pressure  or [heart rate] less than 60 for hypertension. "  It was observed during med pass, Employee #-10 administered Lisinopril 40mg to Resident #E2. Resident ' s blood pressure was 108/66, Pulse 72. Blood pressure was retaken and a reading of  103/71, Pulse 75 was obtained. Employee #3  notified the physician of resident ' s blood pressure reading. There was no negative outcome. | | F 309 | | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONS A. BUILDING  B. WING | | | TRUCTION | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX  OR LSC IDENTIFYING INFORMATION) TAG  I | | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 309  F 323  SS=K | Continued From page 44  A face-to-face interview was conducted with  Employee #3 and Employee #10 on January 12,  2011 after he/she administered the Lisinopril tablet. He/she acknowledged that the Lisinopril was not given according to physician ' s parameters. The observation was made on January 12, 2011.  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff  interviews for one (1) of 16 sampled residents and five (5) of 61 supplemental residents, it was determined that facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessments on residents that have been identified as being at risk for elopement and failure to update risk assessments as needed. Residents #16, F1, F2, F3, SAM1 and SAM2.  An Immediate Jeopardy at CFR 483.25 (H) (I) and (2) F323 Accidents and Supervision was identified on January 18, 2011 at 3:13PM. Facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk | | F 309  F 323 | | | 1. Resident# 16 was found and returned safely to the Nursing Center on 01/20/2011. The  resident was discharged to the hospital (United Medical Center) at the time of return. Elopement Risk Assessments were completed immediately on residents Fl, F2, F3, SAM1,  and SAM2 on 01/19/2011. The Security  Department was in-serviced on elopement and updated with names and photographs of residents that are potential elopement risk.  The portable electric heater that was store directly on the floor of room# 758 was removed. The filters were cleaned in the  dryer in the residents' laundry and it no longer leaks. The oxygen rooms on the 6'" and 7'"  floor are now locked and the key is kept with nursing supervisor. All oxygen tanks are secured and stored in carriers in both oxygen rooms.  2. Elopement Risk Assessments were given to all residents in the Nursing Center and completed on 01/24/2011. These residents found to be elopement risk were places under elopement precautions per the facilities elopement policy  and the Security Department was notified. All resident rooms and common areas were check to assure that the environment is free from accident hazards.. | | |  |

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B WING \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) 10

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

10 PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE

DEFICIENCY)

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assessments on residents that have been identified as being at risk for elopement and failure to update risk assessments as needed after a resident had eloped from the facility and had not yet been found. An additional review of charts for all residents currently in the facility was conducted on January

18, 2011. The review revealed "Elopement Risk Assessments" were not completed and/or updated on 74 of 77 of the residents.

The allegation of removal of the IJ situation was received and verified on January 18, 2011 at 6:05

PM and the Immediate Jeopardy was lifted at this time.

The findings include: Policies

The policy entitled, " Care of the Wandering

Residents" effective 12/01/08 stipulated, "Purpose: To ensure the safety of the residents, who have exhibited wandering behavior, the following protocol shall be implemented ...2. Place the resident in a room near the nurse's station when possible for close monitoring of the resident's activities. Place green dot on resident ' s ID [identification] band (code for wanders). Inform security at the front desk to watch out for wandering residents, (picture ID of the resident should be given to security). "

The policy entitled, "Resident Elopement" effective

12/01/08 stipulated, "Procedure: Determining Elopement Risk: 2. The Elopement Risk Assessment is completed by the nursing staff for all residents within 48 hours of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement. "

A review of the Elopement Risk Assessment Form

revealed that there were no guidelines or

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3. The Administrator and the DON in serviced all nursing facility staff and Security Department staff on the Elopement policy and procedure. Per the Nursing Centers Elopement policy, the Social Worker or designee will complete an Elopement Risk Evaluation on all residents on admission, readmission and change of condition. With the use of the elopement risk evaluation tool,if a score of 10 or greater is achieved than preventive strategies will be implemented. The elopement books located with UMC Security Department will be updated with a photograph, floor and room numbers of the residents at risk. When updating the Elopement book, we will document the dates on each new residents photograph. The elopement book will be updated quarterly to reflect any changes in physical appearance, change of risk status and health condition of the resident. All other interventions and/or strategies will be followed according to the Resident Elopement Risk and Wandering policy. The DON or designee will audit the elopement procedures for compliance weekly. The Administrator or designee will make weekly environmental round to assure that the environment is free from accident hazards

4. The DON or designee will present the findings from these audits/rounds to the Quality Assurance Committee monthly (on going)

starting March 2011. 3/6/2011

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| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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| F 323 | Continued From page 46  parameters for facility staff to utilize in the determination of the resident being at risk for elopement.  On January 11, 2011 approximately 9:00AM during tour of the 6th floor unit, Employee #33 stated, "Is it not a shame that[ Resident # 16] eloped from the facility since the weekend and they have not found him/her as yet. "  1. Resident #16 was admitted to the facility on  August 13, 2010.  A review of the nursing notes revealed the following: August 24, 2010 at 11:00 PM, " monitor for  elopement per order. "  August 27, 2010 at 11:00 PM, " ...continue monitoring for elopement..."  November 28, 2010 at 4:00PM, "monitored qhr  [every hour] for elopement"  January 2, 2011 at 3:45 PM revealed, "On rounds at 7:00 AM, received in day room watching TV[television]. Alert and verbally responsive. All 10  AM meds [medication] given and tolerated well.  Ambulate on the hallway without difficulty. Rounding [unable to read] given. At 2:15PM received a call from resident in Room 655A, Stated: "patient seen walking toward metro station. Nursing supervisor notified. Myself and another staff  member went out in search for resident at the metro  area and around the area close by street. Placed a call to the unit spoke to DON who advised us to return back to the unit. Then DC Police came for report. Please follow-up Nursing supervisor. [Notified] the | | F 323 | | |  | |  |
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| F 323 | Continued From page 47  responsible party at 2:25 PM. At this time resident has not returned back to the unit ... "  The December 2010 and January 2011  Psychoactive Medication Monthly Flow Records revealed that Resident #16 was being monitored for roaming around.  Additionally, Resident #16 was not on a schedule to be checked on an hourly bases.  A review of the "Elopement Risk Assessment" was  last completed on August 18, 2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after the resident eloped on January 2, 2011.  The record was reviewed as a closed record  because the resident had not returned to the facility at the time of the survey.  On January 13, 2011 at 10:30 AM a face-to-face interview was conducted with Employee #28 in the main lobby security desk. He/she stated, 'We do not have any pictures of any residents [posted at the main desk]."  On January 14, 2011 at 11:38 AM a face-to-face interview was conducted with Employee # 15. He/she stated, 'We don't know until they notify us of a missing resident. We don't know in advance who the elopers are. We have never known who the residents are that may elope. We never had any pictures of any residents downstairs [at the security  desks]. After they [residents that may have eloped] leave we are notified and we get a picture. We search the grounds and we notify Metropolitan Police Department and give them a report. We  checked the cameras yesterday (January 13, 2011). It was around 1:34 PM on January 2, 2011, the resident was seen exiting the front elevator. He/she sits in the lobby area doing something with his/her shoe. He/she talks to the security officer at the  desk in the main | | F 323 | | |  | |  |

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| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX  OR LSC IDENTIFYING INFORMATION) TAG  , | | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 323 | Continued From page 48  lobby and then exits the building. Had the security officer known that the resident was an eloper, the officer would have escorted the resident back upstairs."  On January 14, 2011 at 6:40PM a face-to-face interview was conducted with Employees #23 and  24 in the main lobby. They showed the SA representative pictures of the resident's that were potential elopers. And they stated that they were inserviced by the previous officer on duty."  A review of clinical records was conducted for other residents identified by the facility to be at risk for elopement and wanders.  2. Resident #F1's clinical record revealed that the " Elopement Risk Assessment" was not completed on admission and not updated as necessary with any change in behavior that would place the resident at risk for elopement.  The November and December 2010 and January  2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F1 was being monitored for wandering.  The Elopement Care Plan was initiated on August  15, 2010 and last updated on December 26, 2010. The nursing notes revealed, "December 5, 2010 at  4:00 PM RT ' s [resident ' s] condition remains stable. Continues pacing along the hallway. Needs constant re-directing and encouragement ...Closely monitored for elopement risk."  According to the "Hourly Round" sheets for December 2010 and January 2011, Resident #F1 was monitored hourly.  There was no evidence in the clinical record that an " Elopement Risk Assessment" was completed on admission and as necessary, and with any change in behavior, which would place the resident at risk for elopement. .  3. Resident #F2 ' s clinical record revealed that | | F 323 | | |  | |  |

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

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B WING \_

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WASHINGTON, DC 20032

01/19/2011

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SUMMARY STATEMENT OF DEFICIENCIES

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(X5) COMPLETION DATE

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the " Elopement Risk Assessment " was not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement.

The December 2010 and January 2011

Psychoactive Medication Monthly Flow Records revealed that Resident #F2 was being monitored for non-compliant.

The Elopement Care Plan was last updated on

December 30, 2010.

A physician' s order dated December 21, 2010 at

7:30AM directed, " D/C [discontinue] every hourly monitoring for elopement. Start to monitor resident for elopement every four (4) hours times two (2) weeks, then every shift. "

The nursing notes revealed, " December 20, 2010 at 12:30 PM, " Remain on hourly rounds 2nd to elopement risk and no attempt noted ...Out of bed to w/c [wheel chair] and propel self around the unit.

The nursing notes revealed, "December 21, 2010 at 3:00 PM, " Started on 04 hr [every four hour] rounds. Monitor for elopement risk. No attempt noted ... "

According to the " Hourly Round " sheets for

December 2010 and January 2011, Resident #F2 was monitored hourly.

A review of the " Elopement Risk Assessment "

was last completed on July 29, 2010. There was no evidence in the clinical record that an "Elopement Risk Assessment " was updated as needed after July 29, 2010 and after the physician's order on December 21,2010.

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4. Resident #F3 ' s clinical record revealed that the

"Elopement Risk Assessment" was not updated

on admission, as necessary, and with any change in behavior which would place the resident at risk for elopement.

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|  | | | F 323 | | |  | |  |
| F 323 | Continued From page 50  The November 2010 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for agitation and psychiatric disorder; and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for anxiety and agitation.  The Elopement Care Plan was last updated on  December 23, 2010.  The nursing notes revealed, "November 9, 2010 at  11:00 PM, " ...Patient collected his/her bag, [stated] that his/her room is on [the] 1st floor. All attempts [made] for him/her to go back to his/her room [was] to no avail. Attempted to get to the elevator,  security called and was sent back to his/her room  "  The record lacked evidence that hourly rounds and  the elopement risk assessment was completed after the aforementioned episode.  The Treatment Administration Record dated December 21, 2010 directed, "Every four (4) hours Round monitoring 2nd to elopement risk times two (2) weeks, then every shift. " There was no documentation in the clinical record to support why this order was initiated.  According to the " Hourly Round " sheets for December 2010 and January 2011, Resident #F3 was monitored hourly.  A review of the " Elopement Risk Assessment "  revealed that it was last completed on May 20,  2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after May 20, 2010.  On January 14, 2011 at approximately 10:45 AM a face-to-face interview was conducted with Employee# 7. He/she acknowledged that there was no elopement risk assessment completed for Resident ' s #F1, F2 and F3.  5. Facility staff failed to assess the resident for | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING \_ \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 323  I | Continued From page 51  elopement risk on admission and to identify behaviors which would place the resident at risk for elopement. Resident #SAM1.  Record review revealed that resident was admitted  to the facility on November 11, 2010 with diagnoses of : history of Schizophrenia, Hypertension, status post CVA [Cerebral Vascular Accident] and Dementia.  Nurse ' s note dated November 13, 2010 at 2:00 AM  " Due to resident continuously walking in hallway and refusal to stay in bed, given one tablet po [by mouth] of 50 mg Trazodone. ' Resident states what time does the bus come? "Reassured him/her  about place and time and escorted him/her back to his/her room. "  Nurse ' s note dated November 13, 2010 at 4:00AM " Resident continues to walk the hallways and enter other residents ' rooms. Requires constant monitoring.  Nursing documentation from November 13, 2010 through December 27, 2010 reveals that the resident is constantly walking the unit hallways and entering other resident rooms. Resident with aggressive behaviors toward staff and other residents.  Nurses note dated December 27, 2010 at 4:45 PM Resident alert, 008 [out of bed] ambulating, verbally [with] the staff tried to get the elevator today  "  Nurses note dated January 15, 2011 at 8:00AM Resident was seen in the back elevator@ [at] 5:00  AM by a nurse. Resident was redirected back to his/her room. Copies of resident's picture sent to security. Responsible party [name] made aware..MD also made aware. Hourly monitoring in progress for elopement risk.  Physician ' s order January 25, 2011 " Hourly monitoring for resident when ...[unable to read word] 2/2 Elopement risk Q[every] shift. " | | F 323 | | |  | |  |
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

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(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B. WING \_

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01/19/2011

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SUMMARY STATEMENT OF DEFICIENCIES

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(XS) COMPLETION DATE

F 323 Continued From page 52 I

A review of the clinical record lacked evidence that

an Elopement Risk Assessment had been completed on the resident on admission or with

behaviors that indicate the resident was an I

elopement risk.

A face-to-face interview was conducted on January

18, 2011 at 11:30 AM with Employee# 3 who reviewed the record. He/she was unable to locate an Elopement Risk Assessment on the record.

6. Facility staff failed to assess the resident for

elopement risk following the resident ' s verbalization he/she wanted to leave the facility. Resident #SAM2.

Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included Diabetes Mellitus, Essential Hypertension, and Osteomyelitis of Right foot, The resident had previously resided at a Mental Health Group Home since 1995 prior to requiring acute care and subsequently being admitted to the long term care Facility.

Nursing note dated and signed on December 13,

2010 at 10:30 AM indicated:

" ...resident states: I am going. There will be no more treatment for me. I[am) no longer staying here. "

The record lacked evidence that an Elopement Risk Assessment was completed or that care plan was implemented for elopement risk.

Psychiatrist Consult note completed December 13,

2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home" Okay to discharge to [mental health group home] home with recommended Medications.

F 323

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
| (X4)1D PREf iX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX  OR LSC IDENTIFYING INFORMATION) TAG | | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATI: |
| F 323 | Continued From page 53  Physician ' s order dated and signed December 13,  2010 at 12:20 PM directed, "Psych. Resident may be disch. [discharged] Home-(self care) resume Anchor Health Medical Center."  Physician ' s order dated and signed December 15,  2010 at 1910, directed, "Discharge to home in the  AM".  Physician's order dated December 28, 2010 and signed December 30, 2010 directed, "Hold resident' s Discharge/Planning secondary Anchor Health team unable to secure resident a house".  Resident refused Insulin therapy [sliding scale coverage and /or finger sticks] between January 2,  2011 and January 14,2011.  Record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy.  A review of the clinical record lacked evidence that  an "Elopement Risk Assessment "was completed upon admission and up-dated as needed for Resident #SAM2.  A face-to-face interview was conducted with  Employee #7 at approximately 4:30 PM on January  18, 2011. He/she acknowledged that the record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy. The record was reviewed on January 18,  2011.  B. Based on observations made during the | | F 323 | | |  | |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

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STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

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OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

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(X5) COMPLETION DATE

F 323 Continued From page 54

environmental tour of the facility on January 11 thru January 18, 2011, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by an electric heater that was observed on the floor in one (1) of

19 resident' s rooms, a leaky dryer in one (1) of one

(1) resident laundry room, two (2) of two (2)

unlocked and accessible oxygen rooms and one (1)

I of six (6) oxygen tank that was stored upright and

unsecured.

The findings include:

1. A portable, electric heater was stored directly on the floor of room #758.

2. The dryer in the resident laundry room was leaking.

3. The oxygen rooms on the sixth and seventh floor were not secured and were accessible to residents.

4. One (1) of six (6) oxygen tanks was stored

upright and was not secured in the oxygen room on the sixth floor.

These findings were acknowledged by Employees #

1 and #19 who were present at the time of

observation.

F 323

F 325 483.25(i) MAINTAIN NUTRITION STATUS SS=E UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

F 325

1. No resident was negatively affected by this deficient practice. Resident #2, 5 an 6 were re-weighed according to the Physicians Orders.

2. All other residents were checked that may be affected by this deficient practice to assure that their re-weights have be taken according

to the Physicians order. Those that were found to be out of compliance were re-weighed.

CENTERS FOR MEDICARE & MEDICAID SERVICES

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COMPLETION

DATE

F 325 Continued From page 55

This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of four

(4) of sampled residents, it was determined that facility staff failed to perform reweights according to the facility's policy for four (4) residents. Residents

#1, 2, 5, and 6.

The findings include:

1. Facility staff failed to perform re-weights according to the facilities policy for Resident #1 with a 23.8 pound increase for the month of October.

A review of the Physician's Order sheet signed and dated December 30, 2010 for the January 2011 revealed that Resident #1 had a current diagnosis of HTN (Hypertension) Uncontrolled, Anxiety, Vertigo, and DJD (Degenerative Joint Disease).

A review of the annual "Nutrition Risk Assessment" dated and signed December 20, 2010 revealed in the comments section "Pt.(patient) receiving Ensure + (plus) and Beneprotein although (the word not has a line drawn through it) requested to discontinue by the RD (Registered Dietician) in past

"

Review of the "Dietitian Nursing communication sheet" (signed but no date indicated by the Dietitian) revealed (d) Supplemental Order (Ensure Plus) d/c (discontinue (resident gaining weight, not needed). Further review of the "Resident Monthly Weight Record " revealed that the resident had an August weight of 148.2 and a re-weigh of 148.2 pounds. A September weight revealed a weight of 127.7 and a re-weigh of 129.5. In October the resident had a weight of 153.3 there was no

F 325 3. The DON has in serviced all nursing staff on the weight policy and using the weight

monitoring log. All residents monthly and I

weekly weights will be monitored by the Unit Manager and the Charge Nurses. The Monthl and /or weekly weight variance report is discussed in the weekly risk meeting. A weigh monitoring log has been developed to record weights taken on admission audited weekly.

4. Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May

2011.

3/6/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 56

re-weigh identified for the month of October which revealed a 23.8 pound weight gain between September and October.

A face-to-face interview was conducted with

Employees #6 and #20 on January 12, 2011 at

11:30 AM a query was made as to the policy or protocols for re-weighs and when they are

performed for a resident? Employee #20 interjected

"he/she does not have the policy in front of him/her and could not respond to the query." Employee #6 indicated that he/she can "retrieve the weights from the computer."

Employee #6 presented a 'Weight and Vitals Summary" (no date indicated), print-out that failed to reveal re-weighs for the month of October.

A review of the facility's policy "Resident Weight and Weight Changes" Policy Number Diet SS-815 effective December 1, 2008 revealed: (4): A

re-weigh must be obtained within 24 hours if a

weight change that meets the following criteria is noted:

Interval %of Body weight change

1 week 2%

1 month 5%

3 months 7.5%

6 months 10%

Facility staff failed to perform re-weighs according to the facility's policy for Resident #1 with a 23.8

pound increase for the month of October 2010.

The record was reviewed January 12, 2011.

ID PREFIX TAG

F 325

PROVIDER'S PLAN OF CORRECTION

{EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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| 3. | The DON has in serviced all nursing staff on the weight policy and using the weight monitoring log. All residents monthly and weekly weights will be monitored by the Unit |
|  | Manager and the Charge Nurses. The Monthly |
|  | and /or weekly weight variance report is |
|  | discussed in the weekly risk meeting. A weight |
|  | monitoring log has been developed to record |
|  | weights taken on admission audited weekly. |
| 4. | Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May  2011. |

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2. Facility staff failed to re-weigh Resident #2 according to facility's policy.

According to the facility's "Weight Policy, dated December 1, 2008 stipulates, "Validation of significant weight changes: all residents with a significant weight change will be re-weighed

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| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  TAG OR LSC IDENTIFYING INFORMATION)  I | | | ID PREFIX TAG | | | PROVIDER'S PLAN OF CORRECTION IX5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETION  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | |
| F 325 | Continued From page 57  under the supervision of a licensed nurse within 48 hours. Significant change is defined as:  a. 5% in one month b. 7.5% in 3 months c. 10% in 6 months.  All weights and re-weighs will be evaluated by a registered dietician."  A review of Resident #2's record revealed the following weights for 2010:  August 2010 - 176.5 pounds  September 2010- no weight documented  October 2010 - 179 pounds November 2010- 176 pounds December 2010 - 198 pounds?  According to a quarterly nutrition review dated December9, 2010, "Current weight 198 [pounds]?, current weight appears inaccurate - staff unable to re-weigh d/t [due to] need to calibrate the scale." Nutrition review note dated December 10, 2010 revealed, "[Nursing] staff to notify RD [Registered Dietician] once re-wt [re-weigh] is available. "  There was no evidence that a re-weigh was attempted after the December 2010 weight of 198 pounds.  A face-to-face interview was conducted with Employees #3 and #4 on January 13, 2011 at approximately 1:30 PM. Both acknowledged that there was no re-weigh done on Resident #2. A  re-weigh was done on January 14, 2011 which was  181 pounds. The clinical record was reviewed on  January 13, 2011. | | F 325 | | |  | | |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 325 | Continued From page 58  3. Facility staff failed to perform weekly weights times four (4) following an admissions and readmission according to the facility policy for Resident #5.  A review of the " Physician ' s Order " sheet signed  and dated January 12, 2011 for the month of January 2011 revealed that Resident #5 had a current diagnosis of "A-Fib (Atrial Fibrillation) with RVR (Rapid Ventricular Response), PVD  (Peripheral Vascular Disease), HTN (Hypertension), Dementia, (R ) Right Hemiparesis, Aphasia with  Peg Tube."  Review of the "Admission Order sheet and Physician Plan of Care" dated and signed November 9, 2010 revealed that the resident was admitted on November 9, 2010.  A review of the "Nutrition Care Progress Note" dated and signed November 19, 2010 revealed "Resident in hospital for respiratory distress, will f/u (follow up) with readmissions."  A review of the Nutrition Risk Assessment"  re-admission note dated and signed November 24,  2010 revealed " Resident re-admitted to floor. MD ordered Jevity 1.5 so renal insufficiency likely resolved, current weight from the Anthropometric Data section revealed current weight 150.3 # (pounds)."  A review of the "Nutrition Care Progress Note"  dated and signed December 26, 2010 revealed " Nutrition follow-up " : Significant Change Chart reviewed. Upon visiting resident observed that tube feeding was not at goal rate, asked RN (Registered Nurse) to increase tube feeding .... " "monthly weight: 142.5 #(pounds) (5% loss in one month), plan: (1) will continue to monitor wt (weight) and adjust tube feeding if needed. "  A review of the "Resident Monthly Weight Record" revealed that the resident had an | | F 325 | | |  | |  |
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| F 325 1 Continued From page 59 admissions weight of 150.3 pounds. | | | F 325 | | |  | |  |
|  | The record also failed to identify weekly weights  times four (4) after admissions.  Further review of the facility's "Weights and Vitals Summary" (no date indicated) identified the resident's weight in November as 150.3 pounds. The summary also failed to identify weekly weights times four (4) after admissions and after the readmissions.  A face-to-face interview was conducted with  Employees #20 and #21 on January 13, 2011 at approximately 11:30 AM. A query was made as to when re-weighs are performed and the process for re-weighing a resident? Employee #21 indicated that "weights are due the 5th of every month, if there is a significant change increase or decrease then we will ask for a re-weigh.' Employee #20 was unaware of the facility's weight, weight change or  re-weigh policy or protocol.  A review of the facility's policy "Resident Weight and Weight Changes" Policy Number Diet SS-815 revealed (4) A reweigh must be obtained within 24 hours if a weight change that meets the following criteria in noted:  Interval %of Body weight change  1 week 2%  1 month 5%  3 months 7.5%  6 months 10%  The facility staff failed to perform re-weighs according to the facility policy for admissions, and readmissions for Resident #5. The record was reviewed on January 13, 2011.  4. Facility staff failed to re-weigh Resident #6 according to facility's policy.  According to the facility's "Weight Policy, dated | |

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SUMMARY STATEMENT OF DEFICIENCIES

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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December 1, 2008 stipulates, "Validation of significant weight changes: all residents with a significant weight change will be re-weighed under the supervision of a licensed nurse within 48 hours. Significant change is defined as:

a. 5% in one month b. 7.5% in 3 months c. 10% in 6 months.

All weights and re-weighs will be evaluated by a registered dietician. "

A review of Resident #6's record revealed the following weights for 2010:

November 2010- 138.1 pounds December 2010- 138.1 pounds January 2011 - 148.1 pounds

There was no evidence that a re-weigh was taken after the January 2011 weight of 148.1 pounds.

A face-to-face interview was conducted with Employees #4 and #7 on January 13, 2011 at approximately 1:30PM. Both acknowledged that there was no re-weigh done on Resident #6. Employee# 7 stated, "the bedside scale was missing a pad and resident could not be

re-weighed. A re-weigh was done on January 14,

2011 which was 144.1 pounds. The clinical record was reviewed on January 13, 2011.

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL SS=D NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:

Injections;

F 325

F 328

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(X5) COMPLETION DATE

F 328 Continued From page 61

Parenteral and enteral fluids;

Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;

Tracheal suctioning;

Respiratory care; Foot care; and Prostheses.

This REQUIREMENT is not met as evidenced by: Based on staff observations and staff interview for

two (2) of 16 sampled residents, it was determined that facility staff failed to provide tracheal suctioning according to accepted standards of clinical practice. Residents #2 and #3.

The findings include:

1. Facility staff failed to ensure that Resident #2 received proper treatment and care for tracheal suctioning.

According to "Physician's Orders" dated and signed December 19, 2010 directed, ''Trach care every shift and prn [as needed], Suction [every] shift and as needed."

Employee #10 was observed on January 12, 2011 at approximately 2:25 PM performing Trach care to Resident #2. During preparation for Trach care, Employee #10 opened one sterile catheter kit and created his/her sterile field. Employee #10 then proceeded to remove a previously opened catheter kit tray with a suction catheter exposed from Resident #2 ' s bedside table. He/she then removed the suction catheter from the previously open tray and placed it on the sterile field. At this point the sterile field was contaminated.

F 328

1. The licensed Nurse that failed to provide tracheal suctioning according to accepted standards of clinical practice for residents #2 and 3 were reprimanded and reeducated on correcting that deficient practice.

2. All other licensed Nursing Staff that may do trach care were reeducated on providing tracheal suctioning care.

3. All licensed staff will be given an in service relating to Tracheotomy Care to include Policies on "Suctioning a Tracheotomy Tube and Tracheotomy Care" by the DON or designee. A Competency Validation Tool on Critical Elements for Suctioning will be used. The goal is that all RN/LPN will demonstrate knowledge and skill in suctioning and tracheotomy. Must meet all the critical

elements of the procedure and will be checked

randomly by the unit manager and nursing supervisors weekly for 3 months until each licensed can demonstrate the procedure times five.

4. Findings from these random checks will be presented to the Quality Assurance Committee Monthly starting March 2011.

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| F 328 | Continued From page 62  Employee #10 failed to maintain sterile technique during preparation for Trach care.  According to the "2007 Lippincott' s Nursing Manual " , under Tracheostomy Care Procedure " revealed for sterile tracheobronchial suction by way of tracheostomy .... Equipment ...assemble the following equipment or obtain a prepackaged suctioning kit: Sterile suction catheters ... "  A face-to-face interview was conducted on January  1 12, 2011 at 2:25 PM with Employees #3 and #4. They acknowledged that Employee #10 should have used a new prepackaged sterile suction kit with a catheter in preparing for Resident #2 ' s Trach care.  2. Facility staff failed to suction Trach according to accepted standards of clinical practice during Trach care for Resident #3.  On January 14, 2011 at 9:30AM during a Trach  care observation Employee #22 washed his/her hands and pulled out a suction care kit out of Resident #3 ' s bedside drawer that consisted of sterile gloves, container for normal saline and suction catheter. He/she then put blue clean gloves on, open sterile packet pull sterile suction catheter out of bag, connected suction catheter to suction tubing and ask resident to hold the suction  tubing with the sterile suction catheter attached to it. He/she then removed the blue clean gloves and placed them in garbage bag then without washing his /her hands removed sterile gloves from its container and put them on. He/she opened up the normal saline bottle and poured the saline solution  in the sterile container then took suction tubing with the sterile catheter | | F 328 | | |  | | |
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| F 328 | Continued From page 63  attached back from resident and proceeded with suctioning resident Trach. After Trach suctioning He/she voiced that the Trach care was already done by respiratory. He/she removed all used supply and placed them in garbage bag then cleaned resident table discard trash in biohazard container in soiled utility room and then he/she washed hands.  During observation facility staff failed to use " Professional Standard of Quality " to suction Trach during Trach care.  "Wash hands with antimicrobial soap. Opens equipment and sets up sterile field. Fill the two basins provided in kit with Normal Saline or sterile water. Dons face mask, gown, and goggles (if splashing is anticipated). Dons sterile gloves provided in suction catheter kit. Designate one hand as contaminated for disconnecting, bagging, and working the suction control. Usually the dominant hand is kept sterile and will be used to thread the suction catheter. Use the sterile hand to remove carefully the suction catheter from the package, curling the catheter around the gloves fingers. Connect suction source to the suction fitting of the catheter with the contaminated hand. Using contaminated hand disconnect the resident from the ventilator. Suction inner cannula. Gently insert suction catheter as far as possible into the artificial airway without applying suction, withdraw catheter 2 to 3cm and apply suction. Quickly rotate the  catheter while it is being withdrawn. Limit suction time to no more than 10 seconds. Instill 3-5mI sterile normal saline into the artificial airway during spontaneous inspiration if secretions are tenacious. Rinse catheter between suction passes by inserting tip in cup of sterile water and applying suction. Continue making suction passe, bagging the  resident between passes, until the airways are clear  of accumulated | | F 328 | | |  | |  |

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UNITED MEDICAL NURSING HOME

B. WING \_ \_ \_

095039 01/19/2011

STREET ADDRESS, CITY, STATE, ZIP CODE

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

F 328 Continued From page 64

secretions. Give the patient four to five " sigh " breaths with ambu bag. Return the resident to ventilator. "

Tracheostomy Care Procedure, Fundamentals of Nursing Made Incredibly Easy (2007) Lippincott [www.sh.lsuhsc.edu/policies/policy\_manuals\_via\_ms](http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms)

\_word/Nursing/T-25.pdf

[<http://www.sh.lsuhsc.edu/policies/policy\_manuals\_](http://www.sh.lsuhsc.edu/policies/policy_manuals_)

via\_ms\_word/Nursing/T-25.pdf>

A face-to-face interview was conducted on January

14, 2011 at 9:40AM with Employees #7, #9 and

#22. They acknowledged that Trach suctioning was not provided according to professional standard of practice. The record was reviewed on January 14,

2011.

F 371 483.35(i) FOOD PROCURE,

SS=E STORE/PREPARE/SERVE- SANITARY

The facility must-

(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record

reviews on January 11 thru January 14, 2011, it was determined that facility staff failed to prepare and serve food under sanitary conditions as evidenced by one (1) of one (1) cook-chill bag of cheesy grits, one (1) of one (1) cook-chill bag of chicken gravy, one (1) of one (1) cook-chill bag of

F 328

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F 371

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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|  | | |
| F 371 | Continued From page 65  chicken broth and two (2) of two (2) bags of meat sauce were stored beyond their expiration date; two (2) of three (3) garbage disposals and one (1) of two (2) walk-in freezer were out of order; one (1) of two (2) walk-in freezers was unable to sustain required temperatures; one (1) of two (2) refrigerators had a broken door handle and a torn gasket; 30 of 30 soiled, dented and damaged full sheet pans and five (5) of seven (7) soiled pizza pans; 15 of 15 expired loaves of bread; prematurely recorded entries on  the pots and pans log and the dishwashing machine logs; out of range temperatures on hot and cold foods from the test tray and approximately 100 of  100 serving trays that were inappropriately stored.  The findings include:  1. Food items were stored beyond their expiration date in the walk-in 1 refrigerator including: one  cook-chill bag of cheesy grits with an expiration date of 1-5-11, one cook-chill bag of chicken gravy expired 11-22-2010, one cook-chill bag of chicken broth (1-3-2011) and two bags of meat sauce  (1-10-2011).  2. Essential equipment such as two (2) of three (3) garbage disposals and one (1) of two (2) walk-in freezers were not functioning and had been inoperative for 30 to 60 days.  3. Walk-in freezer #2 was not maintaining the  expected ternperatures of zero to -10 degrees F due to a broken latch at the entrance door.  4. The entrance door to the walk-in 1 refrigerator  would not completely close due to a broken door handle and a torn door gasket.  5. 30 of 30 full sheet pans were soiled, dented and damaged and needed to be replaced.  6. Five (5) of seven (7) pizza pans were soiled with food residue.  7. Fifteen loaves of bread with an expiration date | | F 371 | | | 1. Food items that were stored beyond their expiration date in the walk-in 1refrigerator including: one cook- chill bag of cheesy grits | | |
| with a expiration date of 01/05/11, one cook-chill bag of chicken gravy expired  11/22/10, one cook -<hill bag of chicken broth (01/03/11) and two bags of meat sauce were disposed of at the time of the survey.  Essential equipment such as two of three garbage disposals that were not working was repaired. The walk in freeze that was not working has been taken out of service in order to be rebuilt. This has not affected the operation of the kitchen..  The walk-in freezer#2 that was not maintaining the expected temperatures of zero to ten degrees F due to a broken latch at the  entrance door was repaired.  The entrance door to the walk-in 1 refrigerator that would not completely close due to a broken door handle and a torn door gasket was repaired.  The 30 full sheet pans that were soiled, dented and damaged were discarded and replaced.  The 5 pizza pans that were soiled with food residue were cleaned at the time of the survey.  Fifteen loaves of bread with an expiration date of October 2010 in the walk in freezer #1  was discarded at the time of the survey.  The dietary staff was reprimanded for prerecording the pot and pans sanitizing log and the dishwashing machine log entries. Re educate staff on proper documentation. | |  |

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B WING \_ \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4)1D PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

I

I (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR Y OR LSC IDENTIFYING INFORMATION)

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DEFICIENCY)

F 371 Continued From page 66

of October 2010 were stored in the walk-in freezer

#1.

8. The pots and pans sanitizing log entries and the dishwashing machine log entries for 1-11-2011 were pre-recorded. Copies of both logs were presented to this surveyor at 10:15 am on January

11, 2011 and the afternoon and evening entries had already been documented.

9. Test tray hot foods such as roasted red potatoes (131 degrees F), puree carrots (136 F) and fish (137.5 F) were measured at temperatures below

140 F and cold foods such as milk (59 F), yogurt

(58F), canned peaches (59 F) and iced tea (57 F)

were below the expected cold food temperature of

41 F.

10. Approximately 100 of 100 serving trays were stacked wet, on top of each other.

These observations were made in the presence of Employee# 16 who acknowledged these findings during the survey.

F 425 483.60(a),(b) PHARMACEUTICAL SVC­ SS=D ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel

to administer drugs if State law permits, but only

under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of

F 371

The dietary staff examined the process used in the kitchen for keeping hot foods hot 140F> and Cold foods cold <40F. Reeducate staff on process.

The 100 serving trays that were found wet and stacked on top of each other were rewashed and dried.

2. All other areas in the kitchens that would pertain to these deficient practices stated above we check and corrected if needed.

3. The Dinning Service Director, in serviced the kitchen staff on discarding expired food, repairing or replacing broken equipment, cleaning discarding or replacing soiled, dented and damaged pans. The dietary staff

was reeducated on the proper documentation of the pots and pans sanitizing log and the dishwashing machine log entries. The dietary staff was reeducated on the process used in the kitchen for keeping hot foods hot 140f > and cold foods cold < 40f, also drying serving trays and plates after they come out of the

dish washer. The Dinning Service director or designee will audit the compliance of the cited deficient practices weekly.

4. The findings from the audit will be presented at the quality Assurance meeting monthly

times three March, April and May 2011. 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERJSUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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| F 425 | Continued From page 67  a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by:  I Based on record review and staff interview for one (1) of 16 sampled residents, it was determined that the facility failed to ensure that routine medication was received from the pharmacy and available to be administered to the resident #11.  The findings include:  A review of Resident #11 ' s record revealed a physician ' s order signed January 6, 2011 directed: "Ambien 10 mg by mouth every at bedtime for Insomnia."  A review of the Medication Administration Record for January 2011 revealed that the facility identified that the Ambien was to be administered at 10:00  PM.  Reviews of the January 2011 Medication Administration Record (MAR) revealed that Resident #11 was not administered on January 11 and 12, 2011. The reason written on the reverse side of the January 2011 MAR was "Not available, not given".  A face-to-face interview was conducted with | | F 425 | | | 1. Resident #11 was not negatively affected by this deficient practice.  2. All other residents medication orders were checked for availability and reorder if need for timely distribution.  3. The Licensed nursing staff was reeducated by tl)e | | |
| timely ordering and reordering of resident  DON on reviewing physicians' orders and on  medication. License staff was also in serviced on the use of the emergency medication box in the instance that a resident's medication is not available at the time of need. The DON or designee will monitor the ordering and availability of resident medication weekly.  4. The findings from this monitoring will be reviewed monthly at the Quality Assurance meeting (On Going). The QA committee will recommend any adjustment to the monitoring criteria. | | 3/6/2011 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 425  F 428  SS=D | Continued From page 68  Employee #7 on January 18, 2011 at approximately  3:00PM. He/she stated that the medication had not been delivered from the pharmacy, and the ambien was not given to the resident.  The was no evidence that the facility ensured that ambien was received from the pharmacy in a timely manner to be administered to the resident in accordance with the physician's order.  The record was reviewed January 18, 2011.  483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one  (1) of 16 sampled residents, it was determined that licensed pharmacist failed to review the medication regimen of Resident #5 at least once a month.  The findings include:  Review of the Physician ' s Order dated and signed by the Physician on January 12, 2011 for Resident  #5 revealed that the resident was prescribed eight (8) medications: Allupurinol1OOmg, Aspirin 81mg, Clonidine 0.1mg, Digoxin | | F 425  F 428 | | | 1. Resident# 5 was not affected negatively by this deficient practice..  2. The licensed pharmacist was called to review the medication regimen of all residents of the facility.  3. The Administrator reeducated the pharmacy  1 representative on the CMS Drug Regimen  Review, Reporting Irregularities and Act On Policies. The Pharmacy has communicated to the Administrator of the facility that a licensed pharmacist will review the medication regimen of all the residents in the facility monthly. Should there be an occasion when the  regularly assigned licensed pharmacist is not  available, then the pharmacy will send an alternate replacement. The administrator or designee will monitor the pharmacy for compliance monthly. (On going)  4. Finding from this monitoring will be shared at the Quality Assurance Meeting Monthly. | | 3/6/2011 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 428  F 441  SS=E | Continued From page 69  0.05mg/ml, diltiazem 30 mg, Diovan 320mg, Lovenox injection 60mg/0.6ml, Simvastatin 40mg. A review of the "Chronological Record of  Medication Review " form was last dated November  26, 2010.  A face-to-face interview was conducted with Employee# 2 on January 12, 2011 at 12:13 PM. After review of the medication regimen for Resident  #5 he/she acknowledged the findings and indicated that he/she will inform the pharmacist. The record was reviewed on January 12, 2011.  483.651NFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program  The facility must establish an Infection Control  Program under which it -  (1) Investigates, controls, and prevents infections in the facility;  (2) Decides what procedures, such as isolation,  should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection  (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  (2) The facility must prohibit employees with a  communicable disease or infected skin lesions from direct contact with residents or their food, if | | F 428  F 441 | | | 1. There are no residents that were negatively affected by these deficient practices. The clean linen carts observed uncovered in a  cart from room #606 and in the clean room on the seventh floor were covered at the time of the survey. Employee# 12 was reprimanded for not using the proper infection control practices (using gloves) prior to cutting a resident's fish sandwich.  2. All other linen carts were check for covers. If others were found, they were cover immediately.  3. The DON or designee will reeducate the nursing staff on the proper infection control practices of keeping the linen carts covered and handle resident's food. The DON or designee will monitor this for compliance weekly.  4. The DON or designee will report the findings of this monitoring at the Quality Assurance meeting monthly times three March, April and May 2011. | | 3/6/2011 |
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OMB NO 0938-0391

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UNITED MEDICAL NURSING HOME

095039

B. WING \_ \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) 10

PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

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I (X5) COMPLETION

DATE

F 441 Continued From page 70

direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by: A. Based on observations made during the

environmental tour of the facility on January 11 thru January 18, 2011, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidence by: facility staff failed to decrease the spread of infection by failure to keep clean linen covered in two (2) of two (2) observations and failed to maintain fall mats in accordance with facility policies and procedures. The findings include:

I

1. Facility failed to keep clean linen covered in two

(2) of two (2) observations.

Clean linen was observed uncovered in a cart across from room #606 and in the clean utility room on the seventh floor.

2. Facility failed to maintain fall mats in accordance with facility policies and procedures.

Staff member was observed standing on the floor

mat in room #606 and medical equipment was seen stored on the floor mat in room #750.

These observations were made in the presence

F 441

Past noncompliance: no plan of correction required.

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX  OR LSC IDENTIFYING INFORMATION) TAG | | | | | (EACH CORRECTIVE ACTION SHOULD BE I COMPlETION  PROVIDER'S PLAN OF CORRECTION (XS)  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | |
| F 441 | Continued From page 71  of Employees #1 and #19 who acknowledged these findings during the survey.  B. Based on observations and staff interview of one (1) of 10 supplemental residents, it was determined that facility staff failed to help prevent the development and transmission of disease and infection as evidenced by an employee was observed using his/her bare hands to assist one {1) resident with lunch. Resident #E3.  The findings include:  Facility staff failed to ensure that proper infection control practices were followed to prevent the spread of infections during the lunch meal for Resident #E3.  Resident #E3 was observed during lunch in the dining room on the seventh floor January 14, 2011 at approximately 12:35 PM.  Employee #12 was observed cutting the residents fish sandwich with his/her bare hands.  Facility staff failed to ensure proper infection control practices were followed prior to cutting resident ' s fish sandwich.  A face-to-face interview was conducted with  Employee #3 on January 14, 2011 at approximately  1:20 PM. He/she acknowledged that Employee #12 should have gloves on before cutting resident ' s  fish sandwich and was discussed with Employee  #12. The observation was made on January 14,  2011. | | F 441  F 456 | | |  | |  |
| F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE | | |

OMS NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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*( X*

COMPLETION

DATE

F 456 Continued From page 72

SS=D OPERATING CONDITION

The facility must maintain all essential mechanical, I

electrical, and patient care equipment in safe

operating condition.

This REQUIREMENT is not met as evidenced by: Based on observations made during the

environmental tour of the facility on January 11 thru January 18, 2011, it was determined that facility staff failed to maintain essential patient care equipment in safe operating condition including one (1) of one (1) non-operable bedside scale with a missing pad, loose bed side rail, rusty and leaking

city inlet valve in physical plant, and non-functioning pulse oximeter.

The findings include:

1. The bedside scale for the sixth and seventh floor was missing a pad and could not be used.

2. The right side rails were loose and in danger of falling off the resident ' s bed in room #638 and the left side rails were also loose.

3. The city inlet valve in physical plant was steadily

leaking, was rusty and needed to be replaced. This observation was made in the presence of Employee #1 and #18 who acknowledged the finding during the survey.

4. Facility staff failed to maintain essential patient care equipment in safe operating condition. Resident #6.

Employee #9 was observed monitoring Resident #6

' s blood pressure and pulse ox prior to

F 456

1. The missing pad for the bedside scale for the sixth and seventh floor was found during the time of the survey. The loose side rails on the residents' bed in room #638were tightened. The city inlet valve in the physical plant that was leaking and rusty was replaced. The pulse

oximeter that was cited to be non functioning was taken out of service.

2. All other essential patient care equipment was checked for safe operating conditions. Any equipment not found to be in safe operating condition will be taken out of service and or replaced.

3. The DON or designee will in-service the nursing staff on identifying, documenting and taking out of service essential patient equipment not found in safe operating condition. The DON or designee will monitor this process for compliance monthly.

4. The findings from this monitoring will be

reported to the Quality Assurance Committee

Monthly times three (March, April and May

2011) 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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F 456 Continued From page 73

performing Trach care. He/she was unable to obtain a pulse ox due to the finger pulse oximeter not functioning. Employee retrieved another blood pressure machine with a functional finger pulse oximeter. A pulse ox reading of 99% was obtained on January 14, 2011 at 11:35 AM.

A face-to-face interview was conducted with Employees #4 and #9 during the time of the observation. Both acknowledged that the finger pulse oximeter attachment to the blood pressure machine was malfunctioned and the pulse ox could not be obtained and a work order was entered for repair of the equipment. The observation occurred on January 14, 2011 at 11:25 AM.

F 456

F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT SS=K WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

I

This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff

interviews, it was determined that the administrative staff failed to integrate, coordinate and monitor the facility's practices related to:CFR 483.25 (H) (I) and (2) F323 Accidents and Supervision.

The findings include:

Based on observations, record review and staff interviews for one (1) of 16 sampled residents

F 490

1. Resident# 16 was found and returned safely to the Nursing Center on 01/20/11. The resident was discharged to the hospital (United Medical Center) at the time of return. Elopement Risk Assessments were completed immediately on residents F1, F2, F3, SAM1,

and SAM2 on 01/19/2011. The Security Department was in-serviced on elopement and updated with names and photographs of residents that are potential elopement risk. The portable electric heater that was store directly on the floor of room# 758 was removed. The filters were cleaned in the

dryer in the residents' laundry and it no longer leaks. The oxygen rooms on the 6'h and 7'"

floor are now locked and the key is kept with nursing supervisor. All oxygen tanks are secured and stored in carriers in both oxygen rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X2) MULTIPLE CONSTRUCTION A. BUILDING

B WING \_

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(X5) COMPLETION DATE

F 490 Continued From page 74

and five (5) of 61 supplemental residents, it was

determined that facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed. Residents #16, F1, F2, F3, SAM1 and SAM2.

An Immediate Jeopardy at CFR 483.25 (H) (I} and (2) F323 Accidents and Supervision was identified on January 18, 2011 at 3:13 PM. Facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed after a resident had eloped from the facility and had not yet been found. An additional review of charts for all residents currently in the facility was conducted on January 18, 2011. The review revealed "Elopement Risk Assessments" were not completed and/or updated on 74 of 77 of the residents.

The allegation of removal of the IJ situation was

received and verified on January 18, 2011 at 6:05

PM and the Immediate Jeopardy was lifted at this time.

The findings include: Policies

The policy entitled, "Care of the Wandering

Residents" effective 12/01/08 stipulated, "Purpose: To ensure the safety of the residents, who have exhibited wandering behavior, the following protocol shall be implemented ...2. Place the resident in a room near the nurse's station when possible for close monitoring of the

F 490

2. Elopement Risk Assessments were given to al residents in the Nursing Center and completed on 01/24/2011. These residents found to be elopement risk were places under elopement precautions per the facilities elopement policy and the Security Department was notified. All resident rooms and common areas were check to assure that the environment is free from accident hazards.

3. The Administrator and the DON in serviced all nursing facility staff and Security Department staff on the Elopement policy and procedure. Per the Nursing Centers Elopement policy,the Social Worker or designee will complete an Elopement Risk Evaluation on all residents on admission,readmission and change of condition. With the use of the elopement risk evaluation tool, if a score of 10 or greater is achieved than preventive strategies will be implemented. The elopement books located with UMC Security Department will be updated with a photograph, floor and room numbers of the residents at risk. When updating the Elopement book, we will document the dates on each new residents photograph. The elopement book will be updated quarterly to reflect any changes in physical appearance, change of risk status and health condition ofthe resident. All other interventions and/or strategies will be followed according to the Resident Elopement Risk and Wandering policy. The DON or designee will audit the elopement procedures for compliance weekly. The Administrator or designee will make weekly environmental round to assure that the environment is free from accident hazards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS. CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE  TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | | | | (X5) COMPLETION DATE |
| F 490 | Continued From page 75  resident's activities. Place green dot on resident ' s ID [identification] band (code for wanders). Inform security at the front desk to watch out for wandering residents, (picture ID of the resident should be given to security). "  The policy entitled, "Resident Elopement" effective  12/01/08 stipulated, "Procedure: Determining Elopement Risk: 2. The Elopement Risk Assessment is completed by the nursing staff for all residents within 48 hours of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement. "  A review of the Elopement Risk Assessment revealed that there were no guidelines for facility staff to follow after completing the risk assessment to aide in the determination of the resident being at risk for elopement.  On January 11, 2011 approximately 9:00 AM during tour of the facility on the 6th floor unit Employee #33 stated, "Is it not a shame that Resident# 16 eloped | | F 490 | | | 4. The DON or designee will present the findings from these audits/rounds to the Quality Assurance Committee monthly (on going) starting March 2011. | | 3/6/2011 |
|  | not found him/her as yet. " Further investigation revealed:  1. Resident #16 was admitted to the facility on  August 13, 2010.  A review of the nursing notes revealed the following: August 24, 2010 at 11:00 PM, " monitor for  elopement per order. "  August 27, 2010 at 11:00 PM, " ...continue monitoring for elopement..."  November 28, 2010 at 4:00 PM, "monitored qhr  [every hour] for elopement" | |

from the facility since the weekend and they have

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

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B WING \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(X5) COMPlETION DATE

F 490 I Continued From page 76

January 2, 2011 at 3:45 PM revealed, " On rounds at 7:00 AM, received in day room watching TV[television]. Alert and verbally responsive. All 10

AM meds [medication] given and tolerated well. Ambulate on the hallway without difficulty. Rounding [unable to read] given. At 2:15PM

received a call from resident in Room 655A, Stated:

"patient seen walking toward metro station. Nursing supervisor notified. Myself and another staff member went out in search for resident at the metro area and around the area close by street. Placed a call to the unit spoke to DON who advised us to return back to the unit. Then DC Police came for report. Please follow-up Nursing supervisor. [Notified] the responsible party at 2:25 PM. At this time resident has not returned back to the unit ... "

A review of the "Elopement Risk Assessment" was last completed on August 18, 2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after August 18,

2010.

The December 2010 and January 2011

Psychoactive Medication Monthly Flow Records revealed that Resident #16 was being monitored for roaming around.

Additionally, Resident #16 was not on a schedule to

be checked on an hourly bases.

The record was reviewed as a closed record because the resident had not returned to the facility at the time of the survey.

On January 13, 2011 at 10:30 AM a face-to-face

interview was conducted with Employee #28 in the main lobby security desk. He/she stated, 'We do not have any pictures of any residents [posted at the main desk]."

On January 14, 2011 at 11:38 AM a face-to-face

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION A. BUILDING

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B WING \_ \_

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1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

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F 490 IContinued From page 77 r

interview was conducted with Employee# 15. He/she stated, 'We don't know until they notify us of a missing resident. We don't know in advance who the elopers are. We have never known who the residents are that may elope. We never had any pictures of any residents downstairs [at the security desks]. After they [residents that may have eloped] leave we are notified and we get a picture. We search the grounds and we notify Metropolitan Police Department and give them a report. We

checked the cameras yesterday (January 13, 2011). It was around 1:34 PM on January 2, 2011, the resident was seen exiting the front elevator. He/she sits in the lobby area doing something with his/her shoe. He/she talks to the security officer at the

desk in the main lobby and then exits the building. Had the security officer known that the resident was and eloper, the officer would have escorted the resident back upstairs. "

On January 14, 2011 at 6:40PM a face-to-face interview was conducted with Employees #23 and

24 in the main lobby. They showed the SA representative pictures of the resident's that were potential elopers. And they stated that they were inserviced by the previous officer on duty."

A review of clinical records was conducted for other residents identified by the facility to be at risk for elopement and wanders.

2. Resident #F1's clinical record revealed that the " Elopement Risk Assessment" was completed on admission and not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement.

The November and December 2010 and January

2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F1 was being monitored for wandering.

The Elopement Care Plan was initiated on August

F 490

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| F 490 | Continued From page 78  15, 2010 and last updated on December 26, 2010. The nursing notes revealed, "December 5, 2010 at  4:00 PM RT' s [resident' s] condition remains stable. Continues pacing along the hallway. Needs constant re-directing and encouragement ...Closely monitored for elopement risk."  According to the "Hourly Round" sheets for December 2010 and January 2011, Resident #F1 was monitored hourly.  There was no evidence in the clinical record that an  "Elopement Risk Assessment" was completed on admission and as necessary, and with any change in behavior, which would place the resident at risk for elopement. .  3. Resident #F2 ' s clinical record revealed that the  " Elopement Risk Assessment " was not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement.  The December 2010 and January 2011  Psychoactive Medication Monthly Flow Records revealed that Resident #F2 was being monitored for non-compliant.  The Elopement Care Plan was last updated on  December 30, 2010.  A physician ' s order dated December 21, 2010 at  7:30AM directed, " D/C [discontinue] every hourly monitoring for elopement. Start to monitor resident for elopement every four (4) hours times two (2) weeks, then every shift. "  The nursing notes revealed, " December 20, 2010  at 12:30 PM, "Remain on hourly rounds 2nd to elopement risk and no attempt noted ...Out of bed to w/c [wheel chair] and propel self around the unit.  The nursing notes revealed, " December 21, 2010 at 3:00 PM, " Started on 04 hr [every four hour] rounds. Monitor for elopement risk. No | | F490 | | |  | |  |
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| F 490 | Continued From page 79 attempt noted ... II  According to the II Hourly Round II sheets for  December 2010 and January 2011, Resident #F2 was monitored hourly.  A review of the II Elopement Risk Assessment II  was last completed on July 29, 2010. There was no evidence in the clinical record that an II Elopement Risk Assessment II was updated as needed after July 29, 2010 and after the physician ' s order on December 21, 2010.  4. Resident #F3 ' s clinical record revealed that the  II Elopement Risk Assessment II was not updated of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement.  The November 2010 Psychoactive Medication  Monthly Flow Records revealed that Resident #F3 was being monitored for agitation and psychiatric disorder; and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for anxiety and agitation.  The Elopement Care Plan was last updated on  December 23, 2010.  The nursing notes revealed, II November 9, 2010 at  11:00 PM, II ...Patient collected his/her bag, [stated] that his/her room is on [the] 1st floor. All attempts [made] for him/her to go back to his/her room [was] to no avail. Attempted to get to the elevator,  security called and was sent back to his/her room  II  The record lacked evidence that hourly rounds and the elopement risk assessment was completed after the aforementioned episode.  The Treatment Administration Record dated December 21, 2010 directed, II Every four (4) hours Round monitoring 2nd to elopement risk times two (2) weeks, then every shift. II There | | F 490 | | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A- BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 490  I | IContinued From page 80  was no documentation in the clinical record to support why this order was initiated.  According to the " Hourly Round " sheets for December 2010 and January 2011, Resident #F3 was monitored hourly.  A review of the " Elopement Risk Assessment "  revealed that it was last completed on May 20,  2010. There was no evidence in the clinical record that an " Elopement Risk Assessment " was updated after May 20, 2010.  On January 14, 2011 at approximately 10:45 AM a face-to-face interview was conducted with Employee# 7. He/she acknowledged that there was no elopement risk assessment completed for Resident ' s #F1, F2 and F3.  5. Facility staff failed to assess the resident for elopement risk on admission and to identify behaviors which would place the resident at risk for elopement. Resident #SAM1.  Record review revealed that resident was admitted to the facility on November 11, 2010 with diagnoses of : history of Schizophrenia, Hypertension, status post CVA [Cerebral Vascular Accident] and Dementia.  Nurse ' s note dated November 13, 2010 at 2:00AM  " Due to resident continuously walking in hallway and refusal to stay in bed, given one tablet po [by mouth] of 50 mg Trazodone. ' Resident states what time does the bus come? "Reassured him/her  about place and time and escorted him/her back to his/her room. "  Nurse 's note dated November 13, 2010 at 4:00AM " Resident continues to walk the hallways and enter other residents ' rooms. Requires constant monitoring.  Nursing documentation from November 13, 2010 through December 27, 2010 reveals that the resident is constantly walking the unit hallways and entering other resident rooms. Resident with | | F 490 | | |  | | |
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| TAG | OR LSC IDENTIFYING INFORMATION) | |
| F 490 | Continued From page 81  aggressive behaviors toward staff and other residents.  Nurses note dated December 27, 2010 at 4:45PM Resident alert, OOB [out of bed] ambulating, ver..bally [with] the staff tried to get the elevator today  Nurses note dated January 15, 2011 at 8:00 AM Resident was seen in the back elevator @ [at] 5:00  AM by a nurse. Resident was re directed back to his/her room. Copies of resident's picture sent to security. Responsible party [name] made aware..MD also made aware. Hourly monitoring in progress for elopement risk.  Physician ' s order January 25, 2011 " Hourly monitoring for resident when ...[unable to read word] 2/2 Elopement risk Q[every] shift. "  A review of the clinical record lacked evidence that  an Elopement Risk Assessment had been completed on the resident on admission or with behaviors that indicate the resident was an elopement risk.  A face-to-face interview was conducted on January  18, 2011 at 11:30 AM with Employee# 3 who reviewed the record. He/she was unable to locate an Elopement Risk Assessment on the record.  6. Facility staff failed to assess the resident for elopement risk following the resident ' s verbalization he/she wanted to leave the facility. Resident #SAM2.  Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included Diabetes Mellitus, Essential Hypertension, and Osteomyelitis of Right foot, The resident had previously resided at a Mental Health Group Home since 1995 prior to requiring acute care and subsequently being admitted to the long term care Facility. | | F 490 | | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
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| F 490 | Continued From page 82  Nursing note dated and signed on December 13,  2010 at 10:30 AM indicated:  " ...resident states: I am going. There will be no more treatment for me. I[am] no longer staying here. "  The record lacked evidence that an Elopement Risk Assessment was completed or that care plan was implemented for elopement risk.  Psychiatrist Consult note completed December 13,  2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home " Okay to discharge to [mental health group home] home with recommended Medications.  Physician ' s order dated and signed December 13,  2010 at 12:20 PM directed, "Psych. Resident may be disch. [discharged] Home-(self care) resume Anchor Health Medical Center."  Physician I s order dated and signed December 15,  2010 at 1910, directed, "Discharge to home in the  AM".  Physician I s order dated December 28, 2010 and signed December 30 2010 directed, "Hold resident'  1  s Discharge/Planning secondary Anchor Health team unable to secure resident a house". | | F 490 | | |  | |  |
|  | Resident refused Insulin therapy [sliding scale coverage and /or finger sticks] between January 2,  2011 and January 14, 2011.  Record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to | |

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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) | | I (X5)  COMPI.ETION  DATE |
| F 490 | Continued From page 83  resident's refusal of insulin therapy.  A review of the clinical record lacked evidence that  an "Elopement Risk Assessment "was completed upon admission and up-dated as needed for Resident #SAM2.  A face-to-face interview was conducted with  Employee #7 at approximately 4:30 PM on January  18, 2011. He/she acknowledged that the record  lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy. The record was reviewed on January 18,  2011.  B. Based on observations made during the environmental tour of the facility on January 11 thru January 18, 2011, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by an electric heater that was observed on the floor in one (1) of  19 resident ' s rooms, a leaky dryer in one (1) of one  (1) resident laundry room, two (2) of two (2)  unlocked and accessible oxygen rooms and one (1) of six (6) oxygen tank that was stored upright and unsecured.  The findings include:  1. A portable, electric heater was stored directly on the floor of room #758.  2. The dryer in the resident laundry room was leaking.  3. The oxygen rooms on the sixth and seventh floor were not secured and were accessible to residents.  4. One (1) of six (6) oxygen tanks was stored upright and was not secured in the oxygen room on the sixth floor. | | F 490 | | |  | |  |
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(X5) COMPlETION DATE

F 490 Continued From page 84

These findings were acknowledged by Employees #

1 and #19 who were present at the time of

observation.

F 492 483.75(b) COMPLY WITH

SS=E FEDERAUSTATE/LOCAL LAWS/PROF STD

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

F 490

F 492

1. A qualified Social Worker was hired and started working on 02/14/2011. A History and Physical Examination will be ordered for Resident #9. A comprehensive examination will be ordered for Resident #11. The Social Worker will perform the initial and/or

quarterly social assessments and evaluations for Residents# 5, 6, 8, 9,11, S1and P1in compliance with all applicable State I

regulations. I

This REQUIREMENT is not met as evidenced by:

A. Based on record review and staff interview of two (2) of 16 sampled residents it was determined that facility staff failed to ensure that the residents received a comprehensive medical examination every 12 months. Residents #9 and 11.

The findings include:

In accordance with Title 22 DCMR (District of Columbia Municipal Regulations) 3207.11 "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record.

1. A review of Resident #9's clinical record

revealed an admission date of August 17, 2009. Further review of the clinical record revealed that the last "Report of History and Physical Examination" was dated August 17, 2009.

A face-to-face interview was conducted with Employee #3 on January 13, 2011 at 11:00 AM. After review of the clinical record he/she acknowledged the findings and indicated that medical records would be checked for the document.

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2. All other residents were check that may be affected by this deficient practice to assure that the have a current History and Physical and that the Social Worker or designee has done the initial and/or quarterly social assessments and evaluations. These services will be provided if needed.

3. The new Social Worker will be educated on all policies and procedure pertaining to social services, updated on pending social service issues and work on bring the facility back in compliance with resident social assessments, MDS, care plans and handling resident medically related social services needs etc. The Don or designee will reeducate the Physician on being timely in doing the r residents History and Physical. The Nursing

Managers or designee will keep an on going list of those residents that need to be scheduled

for H&P and contact the Physicians.

4. The Social Worker and Nurse Managers or designee will report their progress at the Quality Assurance meeting monthly.

(on going) 3/6/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:

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A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

B. WING \_

095039 01/19/2011

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

(XS) COMPLETION DATE

F 492 Continued From page 85

Employee #3 failed to produce a History and Physical Examination document for Resident #9 for the year 2010. The record was reviewed on

January 13, 2011.

2. The facility staff failed to ensure that Resident

#11 received a comprehensive examination at least every 12 months.

A review of the current clinical record for Resident

#11 revealed that the History and Physical examination was last completed on September 12,

2009.

The record lacked evidence that a current History and Physical examination was completed 12 months after the September 2009 examination.

A face-to-face interview was conducted with

Employee #7 on January 18, 2011 at 3:00 PM. He/she acknowledged that a current History and Physical was not completed for Resident #11. The record was reviewed on January 18, 2011.

B. Based on record review and staff interview of five (5) of 16 sampled residents and one (1) supplemental resident it was determined that the Social Worker failed to operate and provide services in compliance with all applicable State regulations

as evidenced by failure to perform the quarterly social assessments and evaluations for Residents

#5, 6, 8, 9, 11 and P1.

According to 22 DCMR 3229.5, " The social assessment and evaluation, plan of care and progress notes, including changes in the resident ' s social condition, shall be incorporated in each resident' s medical record, reviewed quarterly, and revised as necessary. "

The findings include:

1. Review of Resident #5's clinical record revealed that the resident was admitted to the facility on November 9, 2010.

Review of the clinical record including the social work section, failed to reveal initial and quarterly

F 492

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

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SUMMARY STATEMENT OF DEFICIENCIES

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(X5) COMPlETION OAT£

F 492 Continued From page 86

assessment notes written by the social worker.. A face-to-face interview was conducted with Employee #2 on January 12, 2011 at 12:30 PM. After review of the clinical record he/she acknowledged the findings and indicated that he/she would check the social worker office and files to see if the notes were filed.

Employee #2 failed to produce social worker notes

written for Resident #5. The record was reviewed on January 12, 2011.

2. The Social Worker failed to perform a social assessment and evaluation for Resident #6.

There was no evidence that the Social Worker had performed any social assessments and/or evaluations since admission.

A face-to-face interview was conducted with

Employee #4 on January 13, 2011 at approximately

12:30 PM. He/she stated, "There are no social services notes in the clinical record."

There was no evidence that facility staff conducted quarterly assessments and evaluations in the progress notes. The record was reviewed on January 13, 2011.

3. The Social Worker failed to perform a quarterly social service assessment for Resident #8.

Review of Resident #8's clinical record revealed that the resident was admitted to the facility on September 15, 2009 with diagnoses which included Depression and Multiple Sclerosis.

Review of the social work section of the clinical record revealed that the last social work assessment was documented on September 15,

2010.

A face-to-face interview was conducted with

Employee #1 at approximately 2:00 PM on

F 492

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
| (X4)1D PREFIX TAG | I 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) | | (X.S) COMPLETlON DATE |
| F 492 | Continued From page 87  January 14, 2011. He/she acknowledged that the record lacked social work documentation/intervention. He/she added, *'We* have not had a social worker for a while but we recently hired one. He/she will be starting to work soon [at the facility]. However, I have been doing everything I can to meet the residents' needs." The record was reviewed on January 12, 2011.  The Social Worker failed to perform a quarterly social service assessment for Resident #8.  4. The Social Worker failed to perform a quarterly social service assessment for Resident #9.  Review of Resident #9's clinical record revealed that the resident was admitted on August 17, 2009. Review of the clinical record revealed that the most recent social worker entry was dated March 9,  2010.  A face-to-face interview was conducted with  Employees #1, #2, #3 on January 13, 2011 at 3:28  PM. They acknowledged the findings and indicated that "There has not been a social worker for four (4) to six (6) weeks and that the Administrator handles family issues and the nursing staff handle routine social issues ... " The record was reviewed on January 13, 2011.  5. The Social Worker failed to perform ongoing quarterly social service assessments for Resident  #11.  Resident #11 was admitted to the facility on  September 11, 2009.  A review of the clinical record, including the social worker section, revealed that an initial social work assessment was completed [no date indicated]. The record lacked evidence that social services quarterly assessments were completed since September 2009.  A face-to-face interview was conducted with  Employee #7 on January 14, 2011 at 3:00PM. | | F 492 | | |  | |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B. WING \_ \_

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) ID I SUMMARY STATEMENT OF DEFICIENCIES

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG I OR LSC IDENTIFYING INFORMATION)

F 492 1 Continued From page 88

He/she acknowledged that there were no social services notes on the resident's clinical record. The record was reviewed on January 14, 2011.

6. The Social Worker failed to perform an initial and

quarterly social service assessment for Resident

S1.

Review of the clinical record revealed that the resident was admitted to the facility on November

30, 2010.

Review of the clinical record, including the social work section, failed to reveal an initial and/or quarterly social service assessment.

A face-to-face interview was conducted with

Employees #1, #2 and #7 on January 13, 2011 at

3:28 PM. They acknowledged the findings and stated, 'There has been no social worker for four (4) to six (6) weeks and the Administration handles family issues and the nursing staff handle routine social issues ... "

The Social Worker failed to perform an initial and

quarterly social service assessment for Resident

S1. The record was reviewed on January 13, 2011.

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F 492

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(XS) COMPlETION DATE.

F 493 483.75(d)(1)-(2) GOVERNING BODY-FACILITY SS=K POLICIES/APPOINT ADMN

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility

This REQUIREMENT is not met as evidenced by:

F 493 1. Resident# 16 was found and returned safely to the Nursing Center on 01/20/11. The resident was discharged to the hospital (United Medical Center) at the time of return. Elopement Risk Assessments were completed immediately on residents Fl,F2, F3, SAM1,

and SAM2 on 01/19/2011. The Security Department was in-serviced on elopement and updated with names and photographs of residents that are potential elopement risk. The portable electric heater that was store directly on the floor of room# 758 was removed. The filters were cleaned in the

dryer in the residents' laundry and it no longer

leaks. The oxygen rooms on the 6th and ih floor are now locked and the key is kept with nursing supervisor. All oxygen tanks are secured and stored in carriers in both oxygen rooms.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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01/19/2011

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SUMMARY STATEMENT OF DEFICIENCIES

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DEFICIENCY)

F 493 Continued From page 89

Based on observations, record review and staff interviews, it was determined that the governing body failed to establish and implement policies regarding the management and operation of the facility related to CFR 483.25 (H) (I) and (2) F323

Accidents and Supervision

The findings include:

Based on observations, record review and staff interviews for one (1) of 16 sampled residents and five (5) of 61 supplemental residents, it was determined that facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed. Residents #16, F1, F2, F3, SAM1 and SAM2.

An Immediate Jeopardy at CFR 483.25 (H) (I) and

(2) F323 Accidents and Supervision was identified on January 18, 2011 at 3:13PM. Facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed after a resident had eloped from the facility and had not yet been found. An additional review of charts for all residents currently in the facility was conducted on January 18, 2011. The review revealed "Elopement Risk Assessments" were not completed and/or updated on 74 of 77 of the residents.

The allegation of removal of the IJ situation was received and verified on January 18, 2011 at 6:05

PM and the Immediate Jeopardy was lifted at this

F 493 2. Elopement Risk Assessments were given to all residents in the Nursing Center and completed on 01/24/2011. These residents found to be elopement risk were places under elopement precautions per the facilities elopement policy and the Security Department was notified. All resident rooms and common areas were check to assure that the environment is free from accident hazards.

3. The Administrator and the DON in serviced all nursing facility staff and Security Department staff on the Elopement policy and procedure. Per the Nursing Centers Elopement policy, the Social Worker or designee will complete an Elopement Risk Evaluation on all residents on admission, readmission and change of condition. With the use of the elopement risk evaluation tool, if a score of 10 or greater is achieved than preventive strategies will be implemented. The elopement books located with UMC Security Department will be updated with a photograph, floor and room numbers ofthe residents at risk. When updating the Elopement book, we will document the dates on each new residents photograph. The elopement book will be updated quarterly to reflect any changes in physical appearance,change of risk status and health condition of the resident. All other interventions and/or strategies will be

followed according to the Resident Elopement Risk and Wandering policy. The DON or designee will audit the elopement procedures for compliance weekly. The Administrator or designee will make weekly environmental round to assure that the environment is free from accident hazards

4. The DON or designee will present the findings from these audits/rounds to the Quality Assurance Committee monthly (on going)

startinMarch 2011. 3/6/2011

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:S10411 Facility 10 HCFD020030 If continuation sheet Page 90 of 102

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTlPLE CONSTRUCTION A. BUILDING

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SUMMARY STATEMENT OF DEFICIENCIES

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ID PREFIX TAG

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F 493 Continued From page 90 time.

The findings include: Policies

The policy entitled, " Care of the Wandering Residents" effective 12/01/08 stipulated, "Purpose: To ensure the safety of the residents, who have exhibited wandering behavior, the following protocol shall be implemented ...2. Place the resident in a room near the nurse's station when possible for close monitoring of the resident's activities. Place green dot on resident ' s ID [identification] band (code for wanders). Inform security at the front desk to watch out for wandering residents, (picture ID of the resident should be given to security). "

The policy entitled, "Resident Elopement " effective

12/01/08 stipulated, "Procedure: Determining Elopement Risk: 2. The Elopement Risk Assessment is completed by the nursing staff for all residents within 48 hours of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement. "

A review of the Elopement Risk Assessment

revealed that there were no guidelines for facility staff to follow after completing the risk assessment to aide in the determination of the resident being at risk for elopement.

On January 11, 2011 approximately 9:00AM during tour of the facility on the 6th floor unit Employee #33 stated, "Is it not a shame that Resident # 16 eloped from the facility since the weekend and they have not found him/her as yet. "

Further investigation revealed: 1

1. Resident #16 was admitted to the facility on

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August13,2010. I

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVlDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  B WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 493 | Continued From page 91  A review of the nursing notes revealed the following:  August 24, 2010 at 11:00 PM, " monitor for elopement per order. "  August 27, 2010 at 11:00 PM, " ...continue monitoring for elopement... "  November 28, 2010 at 4:00 PM, "monitored qhr  [every hour] for elopement"  January 2, 2011 at 3:45 PM revealed, " On rounds at 7:00AM, received in day room watching TV[television]. Alert and verbally responsive. All10  AM meds [medication] given and tolerated well. Ambulate on the hallway without difficulty. Rounding [unable to read] given. At 2:15 PM  received a call from resident in Room 655A, Stated: "patient seen walking toward metro station. Nursing supervisor notified. Myself and another staff  member went out in search for resident at the metro  area and around the area close by street. Placed a call to the unit spoke to DON who advised us to return back to the unit. Then DC Police came for report. Please follow-up Nursing supervisor. [Notified] the responsible party at 2:25 PM. At this time resident has not returned back to the unit ... "  A review of the "Elopement Risk Assessment " was last completed on August 18, 2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after August 18,  2010.  The December 2010 and January 2011  Psychoactive Medication Monthly Flow Records revealed that Resident #16 was being monitored for roaming around. | | F 493 | | |  | |  |
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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMS NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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01/19/2011

( XII) ID SUMMARY STATEMENT OF DEFICIENCIES

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F 493 Continued From page 92

Additionally, Resident #16 was not on a schedule to be checked on an hourly bases.

The record was reviewed as a closed record because the resident had not returned to the facility at the time of the survey.

On January 13, 2011 at 10:30 AM a face-to-face interview was conducted with Employee #28 in the main lobby security desk. He/she stated, 'We do not have any pictures of any residents [posted at the main desk]. "

On January 14, 2011 at 11:38 AM a face-to-face interview was conducted with Employee# 15. He/she stated, 'We don't know until they notify us of a missing resident. We don't know in advance who the elopers are. We have never known who the residents are that may elope. We never had any pictures of any residents downstairs [at the security desks]. After they [residents that may have eloped] leave we are notified and we get a picture. We search the grounds and we notify Metropolitan

Police Department and give them a report. We

checked the cameras yesterday (January 13, 2011). It was around 1:34 PM on January 2, 2011, the resident was seen exiting the front elevator. He/she sits in the lobby area doing something with his/her shoe. He/she talks to the security officer at the

desk in the main lobby and then exits the building.

Had the security officer known that the resident was and eloper, the officer would have escorted the resident back upstairs. "

On January 14, 2011 at 6:40PM a face-to-face

interview was conducted with Employees #23 and

24 in the main lobby. They showed the SA representative pictures of the resident's that were potential elopers. And they stated that they were inserviced by the previous officer on duty."

A review of clinical records was conducted for other

residents identified by the facility to be at

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  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 I (X5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETION  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY) | | |
| F 493 | Continued From page 93  risk for elopement and wanders.  2. Resident #F1's clinical record revealed that the " Elopement Risk Assessment" was completed on admission and not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement.  The November and December 2010 and January  2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F1 was being monitored for wandering.  The Elopement Care Plan was initiated on August  15, 2010 and last updated on December 26, 2010. The nursing notes revealed, "December 5, 2010 at  4:00 PM RT' s [resident' s] condition remains stable. Continues pacing along the hallway. Needs constant re directing and encouragement ...Closely monitored for elopement risk."  According to the "Hourly Round" sheets for December 2010 and January 2011, Resident #F1 was monitored hourly.  There was no evidence in the clinical record that an  " Elopement Risk Assessment" was completed on admission and as necessary, and with any change in behavior, which would place the resident at risk for elopement. .  3. Resident #F2's clinical record revealed that the " Elopement Risk Assessment " was not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement.  The December 2010 and January 2011  Psychoactive Medication Monthly Flow Records revealed that Resident #F2 was being monitored for non-compliant.  The Elopement Care Plan was last updated on  December 30, 2010.  A physician ' s order dated December 21, 2010 at  7:30AM directed, " D/C [discontinue] every | | F 493 | | |  | | |
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| F 493 | Continued From page 94  hourly monitoring for elopement. Start to monitor resident for elopement every four (4) hours times two (2) weeks, then every shift. "  The nursing notes revealed, "December 20, 2010  at 12:30 PM, " Remain on hourly rounds 2nd to elopement risk and no attempt noted ...Out of bed to w/c [wheel chair] and propel self around the unit.  The nursing notes revealed, " December 21, 2010 at 3:00 PM, " Started on 04 hr [every four hour] rounds. Monitor for elopement risk. No attempt noted ... " | | F 493 | | |  | |  |
| According to the " Hourly Round " sheets for  December 2010 and January 2011, Resident #F2 was monitored hourly.  A review of the " Elopement Risk Assessment "  was last completed on July 29, 2010. There was no evidence in the clinical record that an " Elopement Risk Assessment " was updated as needed after July 29, 2010 and after the physician ' s order on December 21, 2010.  4. Resident #F3 ' s clinical record revealed that the  " Elopement Risk Assessment " was not updated of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement.  The November 2010 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for agitation and psychiatric disorder; and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for anxiety and agitation.  The Elopement Care Plan was last updated on  December 23, 2010.  The nursing notes revealed, "November 9, 2010 at  11:00 PM, " ...Patient collected his/her bag, [stated]  that his/her room is on [the] 1st floor. All | | | | |
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OMB NO 0938-0391

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| STATEMENT OF DEFICIENCIES AND PlAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B.WING \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
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| F 493 | Continued From page 95  attempts [made] for him/her to go back to his/her room [was] to no avail. Attempted to get to the elevator, security called and was sent back to his/her room ... "  The record lacked evidence that hourly rounds and the elopement risk assessment was completed after the aforementioned episode.  The Treatment Administration Record dated  December 21, 2010 directed, "Every four (4) hours Round monitoring 2nd to elopement risk times two (2) weeks, then every shift. " There was no documentation in the clinical record to support why this order was initiated.  According to the " Hourly Round " sheets for December 2010 and January 2011, Resident #F3 was monitored hourly.  A review of the " Elopement Risk Assessment "  revealed that it was last completed on May 20,  2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after May 20, 2010.  On January 14, 2011 at approximately 10:45 AM a face-to-face interview was conducted with Employee# 7. He/she acknowledged that there was no elopement risk assessment completed for Resident's #F1, F2 and F3.  5. Facility staff failed to assess the resident for elopement risk on admission and to identify behaviors which would place the resident at risk for elopement. Resident #SAM1.  Record review revealed that resident was admitted | | F 493 | | |  | | |
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| to the facility on November 11, 2010 with | | | | |
| diagnoses of : history of Schizophrenia,  Hypertension, status post CVA [Cerebral Vascular  Accident] and Dementia.  Nurse's note dated November 13, 2010 at 2:00AM " Due to resident continuously walking in hallway and refusal to stay in bed, given one tablet po [by mouth] of 50 mg Trazodone. ' | |  | | |

OMS NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  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) | | (XS) COMPLETION OATE |
| F 493 | Continued From page 96  Resident states what time does the bus come? "Reassured him/her about place and time and escorted him/her back to his/her room."  Nurse's note dated November 13, 2010 at 4:00AM  "Resident continues to walk the hallways and enter other residents' rooms. Requires constant monitoring.  Nursing documentation from November 13, 2010  through December 27, 2010 reveals that the resident is constantly walking the unit hallways and entering other resident rooms. Resident with aggressive behaviors toward staff and other residents.  Nurses note dated December 27, 2010 at 4:45 PM  Resident alert, OOB [out of bed] ambulating, verbally [with] the staff tried to get the elevator today  "  Nurses note dated January 15, 2011 at 8:00AM Resident was seen in the back elevator @ [at] 5:00  AM by a nurse. Resident was re directed back to his/her room. Copies of resident's picture sent to security. Responsible party [name] made aware..MD also made aware. Hourly monitoring in progress for elopement risk.  Physician ' s order January 25, 2011 "Hourly  monitoring for resident when ...[unable to read word] 2/2 Elopement risk Q [every] shift."  A review of the clinical record lacked evidence that an Elopement Risk Assessment had been completed on the resident on admission or with behaviors that indicate the resident was an elopement risk. | | F 493 | | |  | |  |
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| A face-to-face interview was conducted on January  18, 2011 at 11:30 AM with Employee# 3 who reviewed the record. He/she was unable to locate an Elopement Risk Assessment on the record.  6. Facility staff failed to assess the resident for  elopement risk following the resident's | | |

OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A \_ BUILDING  B. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |  |
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| F 493 | 1 Continued From page 97  verbalization he/she wanted to leave the facility. Resident #SAM2.  Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included Diabetes Mellitus, Essential Hypertension, and Osteomyelitis of Right foot, The resident had previously resided at a Mental Health Group Home since 1995 prior to requiring acute care and subsequently being admitted to the long term care Facility.  Nursing note dated and signed on December 13,  2010 at 10:30 AM indicated:  " ...resident states: I am going. There will be no  more treatment for me. I[am] no longer staying here. "  The record lacked evidence that an Elopement Risk Assessment was completed or that care plan was implemented for elopement risk.  Psychiatrist Consult note completed December 13,  2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home " Okay to discharge to [mental health group home] home with recommended Medications.  Physician ' s order dated and signed December 13,  2010 at 12:20 PM directed, "Psych. Resident may be disch. [discharged] Home-(self care) resume Anchor Health Medical Center."  Physician ' s order dated and signed December 15,  2010 at 1910, directed, "Discharge to home in the  AM".  Physician's order dated December 28, 2010 and signed December 30, 2010 directed, "Hold | | F 493 | | |  | |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

B. WING \_ \_

095039 01/19/2011

STREET ADDRESS, CITY, STATE, ZIP CODE

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

(X4)1D PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

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(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

I 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 493 Continued From page 98

resident ' s Discharge/Planning secondary Anchor

Health team unable to secure resident a house".

Resident refused Insulin therapy [sliding scale coverage and /or finger sticks] between January 2,

2011 and January 14, 2011.

Record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy.

A review of the clinical record lacked evidence that an "Elopement Risk Assessment "was completed upon admission and up-dated as needed for Resident #SAM2.

A face-to-face interview was conducted with

Employee #7 at approximately 4:30 PM on January

18, 2011. He/she acknowledged that the record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy. The record was reviewed on January 18,

2011.

B. Based on observations made during the environmental tour of the facility on January 11 thru January 18, 2011, it was detennined that the facility failed to provide an environment that is free from accident hazards as evidenced by an electric 1 heater that was observed on the floor in one (1) of

19 resident's rooms, a leaky dryer in one (1) of one

(1) resident laundry room, two (2) of two (2) unlocked and accessible oxygen rooms and one (1) of six (6) oxygen tank that was stored upright and unsecured.

The findings include:

F 493

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:  095039 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING  8. WING \_ | | | (X3) DATE SURVEY COMPLETED  01/19/2011 | |
| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  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 I (XS)  (EACH CORRECTIVE ACTION SHOULD BE COMPlETION  CROSS-REFERENCED TO THE APPROPRIATE I DATE | | |
| DEFICIENCY) | |  |
| F 493  F 514  SS=E | Continued From page 99  1. A portable, electric heater was stored directly on the floor of room #758.  2. The dryer in the resident laundry room was leaking.  3. The oxygen rooms on the sixth and seventh floor were not secured and were accessible to residents.  4. One (1) of six (6) oxygen tanks was stored  upright and was not secured in the oxygen room on the sixth floor.  These findings were acknowledged by Employees#  1 and #19 who were present at the time of observation.  483.75(1)(1) RES  RECORDS-COMPLETE/ACCURATEAl CCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for one (1) of 16 sampled residents, it was determined that facility staff failed to document transition plan for discharge medications for Resident #14. | | F 493 1 | | | | | 3/6/2011 |
| F 514 | | | L Resident #14 was not negatively affected by this deficient practice. The resident was discharged on 12/16/2010.  2. The charts were review for all other discharged  residents to assure that a signed physician discharge summary had been completed and a documented transition plan for medication  was present. If the discharge summery was missing, one will be requested from the resident's physician.  3. The DON or designee will reeducate the  Physicians and the license nursing staff on the importance of having the physicians discharge summery present on a discharged residents chart within 30 days of discharge and a medication transition plan. The DON or designee will audit discharged residents charts for physicians discharge summaries and medication transition plans monthly.  4. The DON or designee will report the findings  of this audit at the Quality Assurance Meeting  Monthly times three (March, April and May  2011) | |

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

UNITED MEDICAL NURSING HOME

095039

B. WING \_

STREET ADDRESS, CITY, STATE, ZIP CODE.

1310 SOUTHERN AVENUE, SE

WASHINGTON, DC 20032

01/19/2011

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(E.ACH 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)

I (X5)

COMPLETION

I DATE

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F 514 Continued From page 100

The findings include:

A. Facility staff failed to document transition plan for discharge medication for Resident #14.

Resident #14 was admitted to the facility on November 24, 2010, with a [chief complaint] of [Status Post Blount Trauma].

An interim telephone order dated December 16,

2010 at 10:30 AM directed "May discharge resident home today."

A review of the nurse's note dated December 16,

2010 at 3:00PM revealed, "[Medical Doctor] requested resident to call unit back with pharmacy of choice and medication will be called to the pharmacy .....Awaiting for his/her call of Pharmacy phone number for his [medications]. "

The clinical record Jacked evidence of any follow up documentation regarding resident ' s discharge medications. "

A face-to-face interview was conducted with

Employee #4 on January 18, 2011. He/She acknowledged that the record lacked transition

notes regarding follow up on discharge medications. He/she stated, "The resident did call back with the pharmacy phone number and his/her medications were called in to the pharmacy. " The clinical

record was reviewed on January 18. 2011.

B. Physician failed to write discharge summary within 30 days of discharge for Resident #14.

Resident #14 was admitted to the facility on November 24, 2010, with a [chief complaint] of [Status Post Blount Trauma].

An interim telephone order dated December 16,

2010 at 10:30 AM directed "May discharge

F 514

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| NAME OF PROVIDER OR SUPPLIER  UNITED MEDICAL NURSING HOME | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  1310 SOUTHERN AVENUE, SE  WASHINGTON, DC 20032 | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES ID I PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE | | | | | | | (X5) COMPLETION DATE |
|  | | | | | DEFICIENCY) | |
| F 514 | Continued From page 101 F 514 resident home today. II  A review of the nurse's note dated December 16,  2010 at 3:00 PM revealed, 11 Resident discharged home this morning per Doctor ' s orders. Resident requested discharge. Evaluated by the psychiatrist on December 13, 2010 and deem fitfor discharge. Writer spoke with mother who confirmed resident has a safe place to return to. Physician's Orders received by writer by phone. II  The clinical record lacked evidence of any documented discharge summary from the physician for Resident #14 who was discharged on December  16, 2010.  A face-to-face interview was conducted with Employee #4 on January 18, 2011. He/She acknowledged that the record lacked a physician discharge summary. The clinical record was reviewed on January 18. 2011. | | | | |  | |  |
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