Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING _____ B. WING	C 01/03/2018

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

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L000	Initial Comments A complaint investigation for C-18-008, DC-3461, was initiated on October 26, 2017. The following deficiencies were based on observation, staff and resident interviews and record review. The sample size was 18 residents. Abbreviations AMS - Altered Mental Status G-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS- Emergency Medical Services (911) HVAC - Heating Ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L- Liter Dl - Deciliter CMS - Centers for Medicare and Medicaid Services Lbs- Pounds (unit of mass) MAR- Medication Administration Record MD- Medical Doctor MDS- Minimum Data Set Mg- Milligrams (metric system unit of mass) mL- Milliliters (metric system measure of volume) mg/dl - Milligrams per Deciliter mm/Hg - Millimeters of Mercury POCT - Point of Contact POS - Physician ' s Order Sheet Prn - As needed	L000		

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L000	Continued From page 1 Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission Screen and Resident Review ARD - Assessment Reference Date IDT- Interdisciplinary Team ID- Intellectual Disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, RIP- Responsible Party PO-By Mouth	L000		
L001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interviews, it was determined that facility staff failed to maintain at least one (1) of three (3) glucometers to be immediately available for emergency use. The findings include: According to the facility's policy, "Accu-Chek Inform II Glucose Meter Test Procedure," POCT 12.1, last reviewed June 28,2017, the following was noted on page 13 of 15: "Quality Control (QC) Testing: The following will be performed on each new day of testing to confirm the test procedure performance before testing any patient specimen. a. The assigned normal and abnormal control	L001	**1.** An investigation was conducted. Two employees were disciplined as a result of investigation and according to policy. Resident #1 was transferred to the ED immediately where he was pronounced. **2.** No other resident was found to have been affected by this deficient practice. The medical records of all residents with a diabetes diagnosis and orders for blood sugar monitoring have been identified. All accu-check monitors were calibrated, serviced and supplies stocked **3.** To prevent future occurrences and to ensure availability for emergency use, one Glucose Meter has been identified (labeled), on each unit and will be recalibrated at 1:00am daily. All licensed nursing staff will be re-educated on the "Accu-Chek Inform II Glucose Meter Test Procedure", to include the Quality (QC) Testing calibration, to ensure compliance.	9/4/17 9/6/17 8/25/17 1/7/18 1/7/18 1/16/18 Ongoing

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L001	Continued From page 2 solutions will be tested. b. The control solutions results must fall within their pre-established ranges before any patient testing can be performed. c. The QC reagents with other information must be recorded on the Glucose Meter Multi-Task QC Log that is stored in the department POCT QC Notebook ..." On August 25, 2017 at approximately 4:45AM, Resident #2 requested assistance from Employee #4 to "change his roommate (Resident #1)." Facility staff attended to Resident #1, who required incontinent care. Resident #1 subsequently slid off the bed onto the floor and required four (4) staff members to place him/her back in bed. At that time, Resident #1 became unresponsive. Facility staff assessed the resident and Employee #4 took his/her blood sugar. CPR was initiated and the resident was transferred to the emergency room, where he was pronounced at 6:01AM. According to Employee #4's written statement, "At about 4:42 AM on 8/25/17, the resident in room 7** came to the nursing station and stated that "my roommate needs to be changed." I was the only one visible at the nursing station at the time because the other two charge nurses and the CNAs were at the back nursing station. I called the charge nurse who had that assignment Employee #5 and told him/her that his/her resident in room 7** need to be changed. He/she now called the CNA and they both went to the resident. At no point did the charge nurse or the CNA who went to the resident say that the resident was in distress other than resident needed to be changed...Resident was assessed for injuries, no apparent injuries noted, was not in any acute distress, was lifted off the floor by four nurses back to his/her bed. I told the nurse that they need to get his/her vital signs while I went to	L001	The night shift nursing supervisor will be responsible for ensuring nightly calibration of glucometers on each unit. 4. Audits of Glucose Meter Daily Test logs will be conducted by the Unit Manager/designee daily and added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be provided to the DON who will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 1/16/18	Ongoing Ongoing

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L001	Continued From page 3 get the glucometer to do finger stick on the resident. I tried three different glucometers but was not able to use anyone of them because they have not been calibrated. I ended up calibrating one of the meters before I could check his/her sugar. The charge nurse and the CNAwas with the resident at the time providing care to him/her and the resident was not in any acute distress ..." A telephone interview was conducted on October 27, 2017 at 9:40AM with Employee #4 regarding the use of the glucometers on August 25, 2017 at 1:00 PM. He/she stated, "The glucometers have to be calibrated after midnight every night. They won't work otherwise. It is built into the machine. They are usually calibrated right before the morning blood sugars (6:00AM). That night I tried each of the glucometers and they had not been calibrated by the night shift yet. I calibrated one of the meters so I could use it to test Resident #1's blood sugar. He/she is a diabetic. It took me two to three minutes, maybe less. The meters were not broken. They were just not calibrated." Facility staff failed to maintain at least one (1) of three (3) glucometers to be immediately available for emergency use. Employee #6 acknowledged the above in a telephone interview conducted on November 13, 2017. The record was reviewed October 26, 2017.	L001		
L051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L051		

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L 051	Continued From page 4 (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on a review of a surveillance video and audio tape, record review and staff interviews, in an isolated incident for Resident #1, it was determined that facility staff failed to document an assessment of the resident's respiratory status after he/she complained that he/she could not breathe. The findings include: Resident #1 was admitted to the facility on July 27, 2017. According to the Minimum Data Set (MDS) assessment with an assessment reference date of August 3, 2017, Resident #1 scored 11/15 on the Brief Interview for Mental Status in Section C (Cognitive Patterns). According to the "MDS 3.0 User's Manual" page C-14, a score of "8-12" suggests that the resident has "moderately impaired" cognitive skills for daily decision making. Resident #1 was assessed as	L051	1. **Resident #1** expired on 8/25/17. 2. All residents had the potential for being impacted by this deficient practice. As a result, Unit managers/designees are conducting hourly rounds for observation and monitoring of resident's condition Respiratory assessment competencies are being completed for all licensed nursing staff to validate assessment and documentation skills. Unit Managers/Supervisors will review the 24 hour report daily to ensure appropriate assessment, treatment and documentation on residents with changes in respiratory status. Corrective action will be implemented as required. 3. To prevent future occurrences, licensed staff were educated on respiratory assessments, treatments and documentation. Certified Nursing Assistants were educated on observation, change in condition and timely reporting to licensed staff.	Ongoing Ongoing Ongoing 2/12/18 and ongoing 1/12/18 and ongoing

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L051	Continued From page 5 requiring limited assistance with eating, extensive assistance with bed mobility, transfers, dressing, toilet use and totally dependent for personal hygiene and bathing. Resident #1 was assessed with limited mobility of both upper and lower extremities on one side in Section G (Functional Status). Disease diagnoses listed in Section I included: HIV+, Toxoplasmosis, Diabetes Mellitus, Cerebrovascular Accident with Hemiplegia/Hemiparesis, Hyponatremia, Cerebral Edema, Candidiasis, Thrombocytopenia, Malaise, Manic-Depression, and Vitamin D Deficiency. According to the surveillance audio and video tape reviewed on November 14, 2017 and again on December 4, 2017 with enhanced audio, the following was noted: "4:50AM Resident #1 says "I can't breathe help me up." Further conversation can be heard between Employee #5 and Resident #1 but not understandable." The following nurses' notes were reviewed: August 24, 2017 at 23:16 (11:16 PM): "Resident is alert and verbally responsive, no acute distress noted, routine meds was given and tolerated well. Finger stick was done, insulin coverage was given per sliding scale. Heparin therapy, no active bleeding noted, was provided with ADL care. Resident continue on rehab program for maximum bed mobility and total transfer continues." August 25, 2017 at 06:55 (6:55AM): "At 11 pm, writer went round to check on resident. Resident #1 was observed lying down on his/her bed alert and responsive. No complain of pain or respiratory distress voiced or observed. Bed was	L051	4. Audits of the monitoring of respiratory assessments and documentation will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be provided to the DON who will present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 2/12/18	Ongoing

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L051	Continued From page 6 at lowest position and call light was within reach. At 2:45 AM during the rounds, Resident #1 was observed watching TV. No complain voiced. At 5:10 AM Resident #1 call light came on and writer went to the room to answer the call light, resident's roommate was sitting on his wheelchair beside the resident's bed and writer observed the resident bed at high position. Resident stated "come and clean me up" his legs were hanging down by the bed side and writer quickly attempted to lower the bed down to prevent resident from falling from the bed ..." There was no evidence that facility staff assessed Resident #1 after he/she complained of not being able to breathe. Employee #2 acknowledged the above findings in a telephone interview on January 3, 2018 at 4:00 PM. The record was reviewed October25, 2017.	L051		
L206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff and resident interviews for one (1) of four (4) residents, for Resident #1, it was determined that facility staff failed to accurately complete an incident report that was received by the Department of Health (DOH) on August 25, 2017 at 4:54pm and failed to inform DOH of a transfer of Resident #1 to the emergency room in a timely manner.	L206	**1. Resident #1** expired on 8/25/17. The employee was re-educated on timely completion, DOH notification and submission of incident reports. 2. No other resident was impacted by this deficient practice. The medical records of all Emergency Department transfers from October to present were reviewed to ensure timely completion and reporting as required.	12/12/17 and ongoing

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

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L 206	Continued From page 8 down to prevent resident from falling from the bed and his/her roommate started, "do not lower the bed, he/she want to be clean up right now." Writer explained to the resident and his/her roommate that resident may fall out of bed if his/her bed remain up" The roommate get angry and stated cursing the writer. Writer lowered Resident #1 bed to prevent him/her from falling but at this time resident get agitated, he/she trying to slide out of bed and writer eased him/her to the ground on sitting position before lay him/her down on the floor and call for help... Resident was assessed on the floor and alert and responsive continue to request to be clean up. Resident was transferred back to bed. Writer assisted the CNA to clean resident, during cleaning observed the resident was getting disoriented. Care was stopped head on bed elevated 90 degrees called on resident's name but there was no respond, checked his/her vital sign P114, R 26, 8/P 90/47, and Temp 98.6. Oxygen 78% on room air. Noted that his/her pulse dropped to 58 then to no reading. CPR was initiated with 100% oxygen via non-rebreather. MD notified and order received to transfer him/her to ER. CPR continue until he/she got to ER. Resident is self RP but emergency contact was made aware." A face-to-face interview was conducted with Employee #1 on October 26, 2017 at 8:30AM. He/she was asked about the contents of the above cited incident report and stated, "I arrived to work about eight o'clock that morning, I didn't witness anything. I was filling in for Employee #2 who was off. I type the incident reports to be sent to DOH. I typed the incident report for Resident #1. Employee #1 was asked if he/she was aware at the time he/she prepared the incident report of	L206	4. ED transfers has been added as a clinical indicator on the QAPI management dashboard. A "Quality Assessment and Performance Improvement Tool for Acute Care Transfer Reviews" will be used as a Quality Improvement Tool for review, analyzation and to identify opportunities for improvement. The DON will be responsible for monitoring Results of the monitoring will be submitted to the Assistant Administrator (who is responsible for Quality Assurance/Performance Improvement), for root cause analysis, trends, educational needs and care process improvement activities. Results of the review will be reported to the DON and Administrator and at the Quarterly Quality Assurance meeting by the Asst. Administrator. Unexpected deaths and ED transfers has been identified as an area for improvement and will be the focus for a Performance Improvement Project. 5. Corrective Action completion date: 2/12/18	12/28/17 and Ongoing

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

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

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

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L206	Continued From page 11 light came on and writer went to the room to answer the call light, resident's roommate was sitting on his/her wheelchair beside the resident's bed and writer observed the resident bed at high position. Resident stated "come and clean me up" his/her legs were hanging down by the bed side and writer quickly attempted to lower the bed down to prevent resident from falling from the bed and his/her roommate started, "do not lower the bed, he/she want to be clean up right now." Writer explained to the resident and his/her roommate that resident may fall out of bed if his/her bed remain up" The roommate get angry and stated cursing the writer. Writer lowered Resident #1 bed to prevent him/her from falling but at this time resident get agitated, he/she trying to slide out of bed and writer eased him/her to the ground on sitting position before lay him/her down on the floor and call for help... Resident was assessed on the floor and alert and responsive continue to request to be clean up. Resident was transferred back to bed. Writer assisted the CNA to clean resident, during cleaning observed the resident was getting disoriented. Care was stopped head on bed elevated 90 degrees called on resident's name but there was no respond, checked his/her vital sign P114, R 26, B/P 90/47, and Temp 98.6. Oxygen 78% on room air. Noted that his/her pulse dropped to 58 then to no reading. CPR was initiated with 100% oxygen via non-rebreather. MD notified and order received to transfer him/her to ER. CPR continue until he/she got to ER. Resident is self RP but emergency contact was made aware." Employee #2 acknowledged the above findings in a telephone interview on January 3, 2018 at 4:00 PM. The record was reviewed October 25, 2017.	L206		