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

PRINTED: 12/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted on November 2, 2015 through November 9, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 47 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass)	F 000	Please begin typing here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda C Gulley
TITLE: Interim Administrator
(X6) DATE: 1/14/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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 MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews for two (2) of 47 Stage 2 sampled	F 241	1. The Nurse Practitioner was inserviced on Resident's Rights and preserving/enhancing dignity while providing care. Resident #10 was not harmed by the deficient practice. Resident#139 was provided a dignity cover for the urine drainage immediately upon discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 residents, it was determined that facility staff failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality as evidenced by one (1) resident's physical assessment was performed while he/she was having lunch, and one (1) resident who ambulated about the unit holding his/her uncovered urine drainage bag. Residents' #10 and # 139. The findings include: 1. Facility staff failed to maintain Resident #10's dignity when the Nurse Practitioner performed a physical assessment on the resident while he/she ate lunch. On November 3, 2015 at approximately 12:30PM, during the dining observation Resident # 10 was observed seated at the table in the day/dining room having his/her lunch. The nurse practitioner was observed with a stethoscope hanging from his/her ear and with the bell of the stethoscope in his/her hand moving across the resident ' s back area. The nurse practitioner then placed the stethoscope around his/her neck. With the resident still seated at the table, the nurse practitioner then pulled the resident away from the table and examined both of his/her foot in the presence of other residents and others in the dining room. There was no evidence that the nurse practitioner enhanced the resident's dignity or respect by	F 241	2. All staff have been instructed to intervene when a Resident's dignity is compromised and immediately report incident to facility leadership. All residents with indwelling catheters were checked to ensure coverage of urine drainage bag. Any identified issues were corrected. 3. To prevent future occurrences, all staff will be in serviced on Residents rights and preserving/enhancing dignity. 4. Random observations of the day rooms will be made to ensure that all residents are treated with dignity and respect for 3 months. Monitoring of residents with foley catheters will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed at quarterly Quality Assurance meeting. The Quality Assurance Committee (QAC) will ensure oversight and correction of any identified issues. 5. Responsible individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 performing an assessment on the resident in the presence of others. A face-to-face interview was immediately conducted on November 3, 2015 at approximately 12:30 PM with the nurse practitioner who acknowledged the findings. 2. Facility staff failed to promote care to enhance the dignity of Resident #139 who was observed ambulating about the unit with the urine drainage bag uncovered and in view of residents and visitors. A review of the clinical record revealed that Resident #139 was admitted to facility on August 24, 2015 with a diagnosis which included BPH (benign prostatic hyperplasia) with urinary retention. A review of the hospital discharge summary dated August 23, 2015 revealed " Patient has a history of BPH (benign prostatic hyperplasia) and was previously discharged from [Hospital Name] with a Foley. Throughout admission, multiple voiding trials were attempted. Patient retained urine, however and the Foley was replaced ...On discharge, patient was maintained on a Foley..." A review of the physician ' s order dated and timed November 1, 2015 at 7:00 PM directed, " Strap Foley catheter to leg with strap [the strap attaches to ones leg and allows free/easy movement. The strap is attached to a leg	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 drainage bag placed under ones clothing and is not visible to the public] q (every) shift " . Observations: A tour of the 6th floor nursing unit was conducted on November 3, 2015, at approximately 8:45 AM. At this time Resident #139 was observed ambulating in hallway carrying his/ her urine drainage bag with clear yellow urine in the tubing, the bag and exposed to other residents and visitors. Resident #139 was observed ambulating in hall on November 3, 2015 at approximately 1:00 PM carrying his/her urine drainage bag in his/her right hand clear yellow urine was in the tubing, the bag and exposed to other residents and visitors. There was no evidence that facility staff obtained a leg strap in accordance with the physician's order; or provided the resident with a leg drainage bag to ensure his /her dignity was maintained. A face-to-face interview was conducted with Employee # 4 on November 4, 2015 regarding the resident ambulating with urine drainage tubing and bag exposed to the public. He/ she acknowledged the aforementioned findings. The clinical record was reviewed on November 4, 2015.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 47 Stage 2 sampled residents, it was determined that the facility staff failed to honor one (1) resident's preference for showers. Resident #95. The findings include: On November 3, 2015 at approximately 10:00 AM, a face-to face interview was conducted with Resident #95. When asked if the resident chose how many times a week he/she took a bath or shower, the resident's stated, "No, I do not receive showers and have only had two (2) since I arrived here both were done with a the help of a friend. " They do bring me wash cloths and towels to wash up but have never offered me a shower. " A review of Resident #95 ' s Minimum Data Set (MDS) Section G Functional Status revealed that he/she was coded as requiring physical help for the bathing activity and the Resident is wheel chair dependent. A review of Activities of Daily Living Sheets (ADL) dated October and November 2015 revealed that the resident was checked for receiving bed baths on his/her designated shower days instead of a shower.	F 242	1. Resident #95 received a shower on 11/6/15 and is scheduled to receive two showers/weekly. 2. Bath/shower sheets of all residents was reviewed to ensure that residents' preferences are honored. Any identified issues were addressed. 3. Nursing education section missing completion date. 4. To prevent future occurrences, the Clinical Manager/designee is monitoring shower/bath documentation and randomly observing showers to ensure that schedules are followed. Performance will be reviewed daily at stand-up meetings for 3 months and during quarterly Quality Assurance meetings. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 6 A review of the unit shower schedule revealed that the resident was scheduled for two (2) showers a week on 3-11 shift Mondays and Thursdays. However, there was no evidence that facility staff offered the resident a shower on the designated days and honored the resident's preference to receive showers. On November 5, 2015 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #4. When queried regarding resident ' s lack of showers, he/she acknowledged the showers had not been offered. The clinical record was reviewed on November 5, 2015.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to promote care for a resident in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality as evidenced by one (1) resident was observed laying on his/her bed with the room light out eating off his/her lunch tray. Resident #104.	F 246	1. The employee assigned to resident #104, was counseled re: assisting preparation of residents for meal time. The resident was not harmed by the deficient practice. 2. Rounds made by the ADON to ensure that all residents requiring assistance during mealtime, received it in an environment that maintains and enhances their dignity and respect eg. Proper positioning, room lights on and assistance with meal consumption, as needed. Any identified issues were corrected. 3. To prevent future occurrences all staff will be in serviced on providing care for a resident in an environment that enhances dignity and respect (resident's rights).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 7 The findings include: On November 3, 2015 at approximately 12:50 PM, during a in room dining observation Resident #104 was observed laying on his/her back with the room light out eating off his/her lunch tray. When queried the resident if he/she was ok, he/she replied, "Turn on that light for me that ' s how they leave me." In the presence of Employee #5, the writer turned the lights on in the resident's room. Employee #5 apologized to resident and proceed to assist the resident to elevate the head of the bed and provided setup help for the resident to eat lunch. A face-to-face interview was immediately conducted on January 3, 2015 at approximately 12:34 PM with Employees #5 at the time of the observation. He/she acknowledged that the resident's room light should have been on and the resident should have been prepared/setup to eat lunch.	F 246	4. Random observations between staff and residents will be conducted by the Clinical Manager/designee to identify dignity issues and to ensure that care is provided in a manner that maintains or enhances each resident's respect. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and Quarterly meetings. The QA committee will ensure oversight and correction of any identified deficiencies. Quality Assurance Committee meetings. 5. Responsible individual: DON	2/9/16
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 8 by: Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to ensure that the resident had an ongoing program of activities that met the residents needs in accordance with the comprehensive assessment as evidence by the resident not participating in out-of-room activities. Resident #16. The findings include: A family interview was conducted on November 4, 2015 at approximately 10:25 AM with Resident #16. A query was asked to the family member, " Does staff encourage [resident name] to attend activities and provide assistance to attend them? " The family member responded " No, they [facility] do not get [him/her] up and [he/she] does not come out of the room for activities. " A review of the medical record revealed that Resident #16 was admitted to the facility on April 6, 2015 with diagnoses which included Diabetes Mellitus, Hypertension, Debility ... " A review of the Quarterly MDS [Minimum Data Set] with an ARD [Assessment Reference Date] of July 15, 2015 and September 18, 2015 revealed Section G Functional Status G0110 " Activities of Daily Living (ADL) Assistance F. locomotion off unit: how resident moves to and returns from off-unit-locations (e.g areas set aside for dining, activities or treatments). If facility has only one floor, how residents moves to and from distant areas on the floor. If not wheelchair, self-sufficiency one in chair) was coded : self performance 8 (eight) : Activity did	F 248	1. Resident #16 has been reassessed to ensure that an activities program is designed to meet his/her interests and physical, mental and psychological well-being. The resident was not harmed by the deficient practice. 2. Each resident was reassessed to ensure that his/her recreational therapeutic needs are met. Any identified issues were corrected. 3. Staff will be re-educated on the delivery of therapeutic activities. Staff competencies will be developed. 4. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and Quarterly meetings. The QA committee will ensure oversight and correction of any identified deficiencies. Quality Assurance Committee meetings. 5. Responsible individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 9 not occur: activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 days; and support : 8 ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time for that activity over the entire 7 day period. " A review of the residents facility " Activity Assessment " date April 7, 2015 revealed the resident preferred " Arts and crafts, board games, Discussions/speakers, entertainers, gardening, movies, television, outings, sing-a-longs, socials ... " A review of the resident's care plan with a review date of October 29, 2015 revealed, " [resident ' s name] is dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] physical limitations, immobility, cognitive deficits... " The resident was observed on several occasions throughout the survey period in room and lying in bed with the television on. No other interaction was observed. A face-to-face interview was conducted with Employee #26 on November 10, 2015 at approximately 11:30 AM. A query was made regarding the resident ' s family member ' s concern of the resident not getting up out of the bed and out of the room for activities. Employee #26 stated, that is a concern, we really need for the staff to get the resident up, into the geri-chair and out-of-the rooms to attend the activities. Recreation Progress Notes:	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 10 A review of the Recreational Progress Note dated August 5, 2015 revealed " [Resident ' s name] does not participate in out of the room activities, probably due to [him/her] have pneumonia and no strength to be motivated to participate ...[His/her] brother will be used along with the Residents Council to advocate for [resident ' s name] to be out of bed and out of room 1-2 [times] a week ... " A review of the " 6th floor 1to 1 Visitation Log " dated June 25, 2015 revealed " visit with [resident name] walk to [his/her] bed side to say hello. [resident name] seem to be asleep. Just made sure that [his/her] T.V. [television] was on in case [he/she] wakes up for sound. " A review of the " 6th floor 1to 1 Visitation Log " dated July 4, 2015 revealed " one to one visit with [resident name] said hello and happy 4th of July, ...I encourage [him/her] to some day get out of bed to visit the day room, and so did [his/her] [family member] ... " A review of the " 6th floor 1 to1 Visitation Log " dated August 20, 2015 revealed " visit with [resident name] was laying look at T.V. I ask[ed] how [he/she] was doing and [he/she] just shake [his/her] head I read the sport[s] page ...left [him/her] listening to music [his/her] roommate was playing ... " There was no evidence that the facility made efforts to ensure that the resident had an ongoing program of activities that met the residents needs in accordance with the comprehensive assessment as evidence by the resident not participating in out-of-room activities. The record was reviewed on November 9, 2015.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 11	F 253		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE 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: Based on observations made on November 4, 2015 at approximately 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: soiled covers to the Air Conditioner/Heating units in five (5) of 26 resident ' s rooms, dusty bathroom vents in 13 of 26 resident ' s rooms, loose privacy curtains in seven (7) of 26 resident ' s rooms, stained privacy curtains in one (1) of 26 resident ' s rooms, torn privacy curtains in one (1) of 26 resident ' s rooms, a fire extinguisher that needed to be recharged on the sixth floor, marred walls in three (3) of 26 resident ' s rooms and a non-functioning door bell on the seventh floor. The findings include: 1. Covers for the Air Conditioner/Heating units were soiled and clogged with paint in five (5)of 26 resident's rooms. Rooms # 619, 644, 702, 718, and 722 2. Bathroom vents were soiled with dust on the inside and outside in 13 of 26 resident's rooms. Rooms #601, 604, 610, 616, 619, 625, 629, 641,	F 253	(1) Covers for the Air Conditioner/Heating units in rooms 619,644,702,718 and 722 were ordered. (2) The bathroom vents for rooms # 601, 604,610,619,625,629,641, 644, 702, 718,750 and 755 were cleaned on the inside and out. (3) Hooks were adjusted for privacy curtains in rooms # 601, 641,637, 702, 718,752 and 755. (4) Privacy curtains in rooms # 644-A and 644B will be replaced (5) Privacy curtain in room #656 (B) will be replaced. (6) The fire extinguisher located across from room #623 has been replaced (7) The marred walls in resident rooms have been repaired (8) The doorbell to the rehabilitation department has been repaired Environmental rounds were conducted on both units to identify and correct any outstanding issues.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 12 644, 702, 718, 750, and 755. 3. Privacy curtains were hanging loosely off the hooks in seven (7) of 26 resident's rooms. Rooms # 601, 641, 637, 702, 718, 752, and 755 4. Two (2) of two (2) privacy curtains were stained in room #644A and 644B. 5. One (1) of two (2) privacy curtain was torn in room # 656 (B). 6. The fire extinguisher located across from room #623 was empty. 7. Walls in three (3) of 26 resident's rooms were marred. 8. The door bell to the rehabilitation department was not functioning. These observations were made in the presence of Employees #29 and/or #30 who acknowledged the findings	F 253	Performance will be monitored during weekly environmental rounds. Identified issues will be immediately addressed or documented in the work order system for scheduled correction. Environmental issues will be added as a quality indicator for review during daily stand-up meetings and addressed during the quarterly Quality Assurance committee meetings. Responsible individual: Administrator	2/9/16
F 272 SS=D	483.20(b)(1) 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 resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 13 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; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for two (2) of 47 Stage 2 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident's cognitive patterns and mood; and for one (1) resident with behaviors. Residents' #16 and #20.	F 272	1. Resident Assessment for Resident # 16 was modified The Resident Assessment for Resident #20 has been corrected 2. An audit was conducted to ensure that Cognitive Level, Mood and Behavior are accurately coded for all residents. Any identified issues were corrected. 3. All social workers were in-serviced on accurate coding of the MDS for resident cognitive patters and moods. 4. To prevent future occurrences Social Workers will conduct monthly audits for MDS accuracy and submit results to Administrator for 3 months. Social Worker will also document and present findings to include corrective actions, at the quarterly Quality Improvement meetings. The QAC will ensure oversight and corrections of any identified issues. 5. Responsible Individual: Administrator	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14 The findings include: According to Chapter 3 of the MDS 3.0 Users ' Manual, Page C-1 " If the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. " 1. Facility staff failed to accurately code Resident #16 for Cognitive Patterns under Section C for and Mood under Section D. A review of the Quarterly MDS dated September 18, 2015 revealed that Resident #16 was coded as the following: " Section B: Hearing, Speech and Vision: B0700 Makes Self understood (Ability to express ideas, wants, consider both verbal and non-verbal expression) was coded " 1 " Usually understands-difficulty communicating some words or finishing thoughts but is able if prompted or given time; B0800 Ability to understand others as " 1 " usually understands - missies some part/intent of message but comprehends most conversation. Section C: Cognitive Patterns: C0100. Should a Brief Interview for Mental Status (C0200-C0500) be conducted was coded " 0 " No (resident is rarely/never understood) Attempt to conduct interview with all residents ... Section C C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be conducted was left blank ... Section D: Mood D0100 should Resident Mood Interview be conducted was coded " 0 " No (resident is rarely /never understood) skip to D0500. "	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 15 A review of the resident ' s Nurses Notes during the seven (7) day look back period revealed the following: September 12, 2015 7:00 AM " Resident is alert and responsive ...Denies pain at this time ... " September 12, 2015 4:30 PM " Resident remain clinically stable s/p [status post] re-admission, alert and verbally responsive ...Resident refused wound dressing to right leg, resident stated , "Don ' t touch my leg ... " September 13, 2015 7:30 AM " Resident alert and responsive ... " September 14, 2015 2:00 PM " Resident alert and responsive ... " September 16, 2015 2:40PM " Resident alert and oriented, verbally responsive ... " There was no evidence in the nursing notes that the resident was unable to speak or answer questions. A review of the Recreational Progress Note dated August 5, 2015 revealed " [Resident name] has adjusted well to [his/her] Nursing Home placement ...[Resident] rarely says much to this writer, however the (gender identified) nursing assistants says [he/she/resident] speaks to them a lot... " The Social Worker Notes dated July 16, 2015 revealed, " Care Plan Note, Quarterly care plan meeting held for resident. RP [Responsible Party] invited but did not attend ...Resident is alert and oriented [time] 2 [person and place], verbally responsive at times ... " There was no evidence in the above clinical notes that the resident could not speak or answer questions.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 16 A face-to-face interview was conducted with Employee #31 on November 6, 2015 at approximately 11:30 AM. He/she state indicated that the resident is able to speak and will answer questions and that [his/her] department is not responsible for this section. A face-to-face interview was conducted with Employee #27 on November 6, 2015 at approximately 12:00 PM. He/she indicated that the resident would not talk to [him/her], however after reviewing the employee ' s notes [he/she] acknowledged the findings. Facility staff failed to accurately code the quarterly MDS for Resident #16. The record was reviewed on November 6, 2015. 2A. Facility staff failed to accurately code Resident #20 ' s Annual [MDS] Minimum Data Set Section E Behavior: Section E0200 Behavior symptoms -Presence - Frequency; E0300 Overall Presence of Behavioral Symptoms, Sections E0500 Impact on Resident and E0600 Impact of Others blank (not coded) and E0800 Rejection of Care - Presence and Frequency. According to CMS ' s RAI Version 3.0 Manual September 2010 page E-5 indicated: " Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days ... " A. Facility staff failed to accurately code the Annual [MDS] Section E0200 Behavior Symptoms -Presence - Frequency for Resident #20.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17 A review of Resident #20 ' s Annual MDS with an Assessment Reference Date of August 26, 2015 revealed in Section E0200 Behavior symptoms -Presence - Frequency was coded " 0 " for Behavior not exhibited for " B " Verbal Behavioral symptoms directed towards others (e.g. threatening others, screaming at others, cursing at others) however a review of the medical record revealed the following nursing notes : August 25, 2015 12:15 PM Writer and a CNA [Certified Nursing Assistant] went into Resident ' s room so that [he/she] can be washed. Writer explained to the resident that two (2) staff will be taking care of [him/her] so as to avoid causing [him/her] pains to [his/her] back so that [he/she] should be comfortable. Resident immediately started picking on the CNA saying words like " you are lazy, you are the only one who doesn't know anything ... " August 25, 2015 03:30 PM " Resident refused all AM medications, stated they are generic not doing any good to [him/her] ...writer and CNA went to resident so CNA can washed [him/her] and clean [him/her], resident refused and curse[d] CNA ... " August 18, 2015 5:00 PM, " I the unit manger was called by charge nurse informing writer that Resident in [room number identified] had some visitors (a man and a woman) and they were collecting stuff such as wipes, soda and lotion and putting them in a small black box. Writer went to the resident ' s room to find out from Resident if at [he/she] authorized them to do that and ...I left the room, writer was later called by	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18 unit secretary that Resident said " I should bring my [black A__] down there ...[He/she poured all kinds of insults on me, such as calling me a "[b___]" ... " Because the behavioral symptoms were observed by staff and reported to others Section 0E200 should have been coded " 1 " , behavior of this type occurred 1-3 days of the last 7 days. Facility staff failed to accurately code the Annual [MDS] Section E0200 Behavior Symptoms -Presence - Frequency for Resident #20. The record was reviewed on November 6, 2015. 2B.Facility staff failed to accurately code the Annual [MDS] Section E0300 Overall Presence of Behavioral Symptoms for Resident #20. According to CMS ' s RAI Version 3.0 Manual September 2010 page E-6 indicated: " Code 1, yes: if any of E0200A, E0200B, or E0200C were coded 1,2,3 ... " A review of the annual MDS Section E0300 Overall Presence of Behavioral Symptoms is to be completed if the response to " Were any behavioral symptoms in questions E0200 coded 1, 2 or 3? was coded " 0 " indicating no behaviors occurred. A review of the aforementioned nursing notes indicated that behaviors did occur, however the section was coded " 0 " indicating to skip to E0800 Rejection of Care, therefore leaving Sections E0500 Impact on Resident and E0600 Impact of Others blank (not coded). Facility staff failed to accurately code the Annual	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 19 [MDS] Section E0300 Overall Presence of Behavioral Symptoms for Resident #20. The record was reviewed on November 6, 2015. 2C. Facility staff failed to accurately code Section E0800 Rejection of Care Presence and Frequency for Resident #20. According to CMS ' s RAI Version 3.0 Manual September 2010 page E-6 indicated: " Code 1, behavior of this typed occurred 1-3 days: if the resident rejected care consistent with goals 1-3 days during the 7 day look back period, regardless of the number of episodes that occurred on any one of those days. " A review of the annual MDS Section E0800 Rejection of Care - Presence and Frequency :Did the resident reject evaluation of care (e.g blood work, taking medications, ADL assistance) that is necessary to achieve the resident ' s goals for health and well-being? ... was coded " 0 " indicating that the " behavior not exhibited. " A review of the aforementioned nurses notes revealed : August 25, 2015 03:30 PM " Resident refused all AM medications, stated they are generic not doing any good to [him/her] ...writer and CNA went to resident so CNA can washed [him/her] and clean [him/her], resident refused and curse[d] CNA ... " A face-to-face interview was conducted with Employee #31 on November 9, 2015 at approximately 11:00 AM. After review of the MDS he/she acknowledged that Section E was not coded correctly. Facility staff failed to accurately code Section E0800 Rejection of Care Presence and	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 20 Frequency for Resident #20. The record was reviewed on November 6, 2015.	F 272	1. The physician was notified and the care plan for Resident #15 was updated to reflect his/her non-compliance (refusal to wear tennis shoes). The resident was not harmed by the deficiency. Any identified issues were corrected. 2. Care plans for all residents were assessed for refusal of treatments. Any identified deficiencies were corrected. 3. The Inter-disciplinary care team will be in serviced on: comprehensive care plan development, reviewing and revising as needed and notifying, documenting resident non-compliance. 4. Clinical Managers/designee will audit care plans monthly to ensure accuracy. Results of the audits will be reported to the DON and presented at the quarterly Quality Assurance Committee meeting. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16
F 279 SS=D	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 §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches to address Resident #15's refusal to wear tennis shoes. The findings include:	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		
	A review of the " Physician ' s Order " dated October 2, 2015 directed, " Patient to wear tennis shoes while in w/c [wheelchair] for positioning.			
	An observation of Resident #15 was conducted on November 4, 2015 at 9:15 AM and 3:20 PM. The resident was observed sitting in his/her wheelchair in the dayroom and wearing gray non-skid socks without tennis shoes.			
	A face-to-face interview was conducted with Employee #5 on November 6, 2015 at approximately 12:00 PM regarding the aforementioned concerns. He/she acknowledged the findings, and further stated that resident does not like to wear the shoes; and would rather wear the non-skid socks.			
	A review of the care plan section of the active clinical record revealed that there was no care plan initiated to address the resident ' s refusal to wear tennis shoes.			
	Facility staff failed to initiate a care plan with goals and approaches to address Resident #15 ' s refusal to wear tennis shoes. The clinical record was reviewed on November 6, 2015.			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		
	The resident has the right, unless adjudged incompetent or otherwise found to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to review and revise one (1) resident's care plan with goals and approaches to address their program related to smoking cessation. Resident #68 The findings include: Facility staff failed to ensure that the smoking care plan for Resident #68 was revised to ensure that the smoking interventions were tailored to address the resident ' s smoking needs. A review of Resident # 68 ' s care plans revealed, " Focus: Resident is a smoker care plan last revised on 09/11/2015 ... Goal: Resident urge to	F 280	1. The care plan for resident #68 was reviewed to ensure goals/interventions are realistic and tailored to address resident's smoking cessation needs. 2. The care plans for all residents who smoke were reviewed to ensure accuracy, realistic goals, and objectives and interventions. Any identified issues were corrected. 3. All licensed staff will be in-serviced on ensuring that goals and interventions are delivered to address resident's smoking cessation needs. 4. To prevent future occurrences, the care plans for all residents who smoke will be monitored to ensure accuracy and inclusion of all smoking-related needs, by the Clinical Managers/designee. Smoking (residents) will be added as a quality indicator for review during daily stand-up meetings 3 months and at quarterly Quality Assurance meetings. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 smoke will decrease in 90 days. Interventions [included] ...Encourage resident to attend classes on how to stop smoking, date initiated 06/11/2012" A face-to-face interview was conducted with the social worker on November 6, 2015 at 12:40 PM, He/she stated, " The resident did not attend a smoking class. " A face-to-face interview was conducted with the social worker coordinator on November 9, 2015 at approximately 1:30 PM. He/she stated, " Smoking cessation classes are not offered here. " A review of the clinical record (nursing notes, physician ' s orders, reports of consultation and social work progress notes) There was no documented evidence that the resident ever attended smoking cessation classes; and there was no evidence that facility staff revised the care plan approaches tailored to the address the residents specific smoking cessation needs. A face-to-face interview was conducted with the Employee # 2 November 6, 2015 at 12:40 PM. He/she acknowledged the findings. The record was reviewed on November 6, 2015.	F 280		
F 309 SS=D	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 comprehensive assessment	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident wore tennis shoes in accordance to physician's orders. Resident #15 The findings include: 1. Facility staff failed to ensure that Resident #15 wore tennis shoes in accordance to physician's orders. According to an annual history and physical dated May 30, 2015, Resident #15 had diagnoses which included: Hypertension, Hx [History of] debility, [History of] Hyperkalemia, Renal Insufficiency, and Depression A physician ' s order dated October 2, 2015 directed, " Patient to wear tennis shoes while in wheelchair for positioning. " Observations of Resident #15 on November 4, 2015 at 9:15 AM and 3:20 PM revealed that the resident was sitting in his/her wheelchair in the dayroom and was wearing gray non-skid socks without tennis shoes.	F 309	1. The resident was not harmed by the deficient practice. The physician's order for tennis shoes was discontinued due to resident's non-compliance. 2. Physician orders for all residents were audited to ensure follow-through. Any identified issues were corrected. 3. To prevent future occurrences, licensed staff will be re-educated on physician's orders, transcription, follow-through and reporting of observations. 4. Compliance monitoring will be conducted by the Clinical Manager/designee. Monitoring will be added as a quality indicator and reviewed daily during stand-up meetings for 3 months and quarterly at the Quality Assurance committee meetings. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/216

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25 A face-to-face interview was conducted with Employee #5 on November 6, 2015 at approximately 12:00 PM regarding the aforementioned concerns. He/she acknowledged the findings. The clinical record was reviewed on November 6, 2015.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident who was admitted with and indwelling urinary catheter [Foley] received appropriate treatment and services to restore or improve normal bladder function to the extent possible as evidenced by failure to follow through with a physician ' s order for a urology consultation; additionally facility staff failed to consistently secure the resident ' s indwelling catheter tubing as directed by the physician. Resident #139 The findings include:	F 315	1. Resident was seen by urologist on November 17, 2015. Foley catheter is strapped to resident's leg shift per physician's order 2. Medical records for all residents, with indwelling Foley catheters were audited to ensure that nursing interventions have been initiated and appropriate treatment and services to restore or improve normal bladder function have been implemented. Any identifications issues were corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 26 Facility staff failed to ensure that Resident #139 was seen for a follow up urology consult in accordance with the physician's orders. Additionally, facility staff failed to consistently secure the indwelling catheter tubing as directed by the physician. A. A review of the clinical record revealed that Resident #139 was admitted to facility on August 24, 2015 with diagnoses that included BPH (benign prostatic hyperplasia) with urinary retention. A review of the hospital discharge summary dated August 23, 2015 revealed " Patient has a history of BPH (benign prostatic hyperplasia) and was previously discharged from [Hospital Name] with a Foley. Throughout admission, multiple voiding trials were attempted. Patient retained urine, however and the Foley was replaced ...On discharge, patient was maintained on a Foley and advised to follow up with urology as an outpatient. " Physician ' s Orders: The physician ' s "Admission Order Sheet" dated and signed August 26, 2015 directed that the Resident be scheduled with urologist for follow up care regarding urinary retention and indwelling Foley catheter. Interim order form dated October 21, 2015 directed, " Urology consult with [physician ' s name] at [Hospital Name] for benign prostatic hypertrophy indwelling Foley catheter." Physician's orders dated and signed October 26,	F 315	3. To prevent future occurrences, all licensed staff will be trained on use of Foley Catheters, treatment, appropriate intervention, urinary tract infections and Bladder rehabilitation retraining. 4. All new admissions and re-admissions with indwelling catheters will be reviewed to ensure that a comprehensive assessment is developed and implemented to ensure appropriate nursing interventions, treatment and services Performance will be reviewed during daily stand-up meetings for 3 months and during the quarterly QA Committee meetings. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 27 2015 directed, " Consults - Urology appt (appointment) with [Name of physician] call [phone number] to schedule." A review of Resident # 139' clinical record lacked evidence of an appointment with the urologist for follow up care regarding urinary retention and indwelling urinary catheter. A face-to-face interview was conducted with Employee #12 on November 4, 2015 at approximately 11:00 AM. The employee was queried regarding the order to schedule a urology consult. He/she acknowledged that Resident #139 ' s urology consult had not been scheduled as initially ordered in August 2015 when he/she was admitted into the facility. A face-to-face interview was conducted with Medical Director on November 5, 2015 at approximately 9:00 AM. He/she acknowledged that Resident # 139 should have been seen by the urologist prior to this meeting. A follow up interview was conducted with Medical Director on November 5, 2015 at approximately 11:00 AM. He/she stated, " The [Resident] has been scheduled for a follow up Urology consultation on November 17, 2015." The record was reviewed November 6, 2015. B. Facility staff failed to ensure that Resident #139 ' s indwelling catheter tubing was secured with a leg strap as ordered by the physician. A review of the physician's order dated and timed November 1, 2015 at 7:00PM directed, " Strap Foley catheter [tubing] to leg with strap q (every)	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 28 shift. " A review of the resident's nurses noted dated and timed November 1, 2015 at 7:00 PM revealed " Around 6:30 PM while giving resident care CNA (certified nursing assistant) noted blood smear on resident ' s diaper and informed writer. On assessment resident was noted with slight irritations around the urethra. Catheter strap was applied to hold Foley in place to avoid further irritation. Resident was educated to avoid moving catheter pulling while trying move around the room ..." Observation: A tour of the 6th floor nursing unit was conducted on November 3, 2015, at approximately 8:45 AM. At this time Resident #139 was observed ambulating in hallway carrying his/ her Foley catheter bag with clear yellow urine in the tubing and drainage bag at waist level. Resident # 139 was observed ambulating in hall on November 3, 2015 at approximately 1:00 PM carrying his/her Foley catheter bag in his/her right hand clear yellow urine was in the tubing and bag at waist level. There was no evidence that facility staff consistently secured Resident #139 ' s indwelling catheter tubing with a leg strap as ordered by the physician. A face-to-face interview was conducted with Employee #12 on November 5, 2015 at approximately 11:00 AM. He/she was queried regarding the indwelling catheter leg strap to secure Resident #139 ' s tubing. He/she	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 29 acknowledged the aforementioned findings. The record was reviewed November 5, 2015.	F 315	1. The residents were not harmed by this deficient practice. Residents #45, #95, #134,#44 and #134 were assessed via the facility's smoking policy and have a current smoking evaluation and care plan in place National Fire Protection Association approved Ashtrays have been purchased and placed in designated smoking area. Signs identifying designated smoking areas are in place.	
F 323 SS=E	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 interview, it was determined that facility staff failed to ensure that the facility was free of potential accident hazards as evidenced by the lack of adequate receptacles to ensure the safe disposal of smoking materials for 16 of 16 residents that engaged in smoking activities. The findings include: According to National Fire Protection Association (NFPA) 2000 Edition, 19.7.4..."3) Ashtrays on noncombustible material and safe design shall be provided in all areas were smoking is permitted. 4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking in permitted." A review of the facility's records revealed that sixteen (16) of 117 residents residing in the	F 323	2. All residents that smoke have been assessed according to facility's smoking policy and have a current smoking evaluation and care plan in place. 3. All staff will be in-serviced on ensuring that facility is free of potential accident hazards. 4. To prevent future occurrences, the Administrator will conduct weekly Environmental rounds to ensure signs for designated smoking area and NFPA receptacles remain in place. Identified issues will be immediately addressed and documented in the work order system for scheduled correction. QAC will ensure oversight and corrections of any identified deficiencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIONS A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30 Facility engaged in smoking activities. A review of the facility's smoking policy read as follows: Smoking Policy, # ADM01-028, Effective date 10/20/15 stipulates: Smoking is only permitted in a designated outdoor smoking area. Smoking cessation is encouraged and interventions are implemented as per physician orders. Purpose: 1. To limit smoking to a specific area for the safety of smokers. 2. To provide a safe and comfortable environment for non-smokers. Procedure: A: General 3. An area designated as a smoking area will be separate from patient care areas (e.g., outdoors), will be well ventilated. 4. Smoking (including electronic cigarettes) will only be allowed in designated areas. H: Safety Measures 1. Designated smoking area will have ashtrays to dispose of smoking materials 2. Security will maintain a "Fire Blanket "at the entrance desk to be used on a resident in case of smoking accident.	F 323	Performance will be reported at the Quarterly Quality Assurance committee meeting. 5. Responsible Individual: Administrator	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIONS A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31 3. Staff member working with supervised smokers will carry "Fire blanket "to designated smoking are while escorting smokers. 4. Staff member will carry a two way radio to communicate with security in case of emergencies. 5. Security will maintain a fire extinguisher at the entrance desk to be used to extinguish a fire as a result of a smoking accident. On November 5, 2015 at approximately 1:15 PM in the presence of Employee #1, the facility's designated outdoors smoking area was observed. Two (2) residents were observed smoking while seated in chairs along the sidewalk adjacent to the main entrance of the facility. Employee #34 was observed standing proximal to the smoking area holding a red bag labeled "fire blanket " and one (1) plastic black ash tray without a cover was observed atop the red bag. There was no cigarette waste (i.e. butts) observed in the ash tray; however multiple cigarette butts were observed scattered along the concrete sidewalk. Employee #1 stated that the staff person supervising smoking activities would offer the residents use of the ashtray. However; s/he acknowledged that the single plastic black ash tray was inadequate and did not encourage and/or ensure the practice safe disposal of cigarette waste. Observations: Residents were observed smoking in front of or near the main entrance of the facility and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTIONS A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32 Surrounding areas as follows: On November 3, 2015 at approximately 08:30 AM, three (3) Residents #45, #95 and #134 were observed smoking cigarettes in front of the main entrance doors of the facility. [There was no smoking receptacle or signage that designated this area as a smoking area]. On November 4, 2015 at approximately 2:00 PM, Residents # 44 and #134 were observed in front of the main entrance doors smoking cigarettes. [There was no smoking receptacle or signage that designated this area as a smoking area]. Resident # 44 was observed smoking in front of the main entrance door on Wednesday, November 4, 2015 at approximately 5:00 PM. [There was no smoking receptacle or signage that designated this area as a smoking area]. On November 5, 2015 at approximately 8:30 AM, Residents #45, and #95 were observed sitting in wheelchairs smoking cigarettes on side walk in front on main there was no smoking receptacle or smoking signage present. On November 5, 2015 at approximately 1:00 PM, Resident #44 was observed smoking cigarettes on side walk in front on main entrance there was no smoking designated signage present. Throughout the survey period cigarette butts were observed scattered along the surface of the sidewalk proximal to the main entrance of the facility. Facility staff failed to ensure that the designated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIONS A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 33 smoking area was equipped with adequate receptacles for the safe disposal of cigarette waste. There was no evidence of signage to designate the area proximal to the main entrance of the building as the "smoking area."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, 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 made on November 2, 2015 at approximately 9:30 AM and on November 4, 2015 at approximately 9:40 AM and on November 9, 2015 at approximately 1:15 PM, it was determined that the facility failed to store and prepare foods under sanitary conditions as evidenced by three (3) of 11 expired packs of chicken broth, four (4) of eight (8) dusty fire suppression heads, 27 of 27 pans that were stored wet, one (1) of three (3) third-pans and two (2) of 15 half-pans that were dented, two (2) of 15 half-pans and three (3) of nine (9) shotgun pans that were soiled and marred and one (1) of one (1) staff member who failed to wear a beard cover on the tray line.	F 371	1. The Executive Sous Chef in serviced utility team on storage standards and proper cleaning procedures. 2. All inventory was checked for expiration dates. The Fire Suppression hoods have been cleaned. The dented pans have been discarded Staff member has been provided beard restraints to use along with wearing a hair net.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 34 The findings include: 1. Three (3) of 11 packs of chicken broth were expired as of October 29, 2015. 2. Four (4) of eight (8) fire suppression heads were soiled with dust particles. 3. Three (3) of three (3) third pans, 15 of 15 half-pans and nine (9) of nine (9) shotgun pans were stored wet. 4. One (1) of three third-pans and two (2) of 15 half-pans were dented. 5. Two (2) of 15 half-pans and three (3) of nine (9) shotgun pans were soiled. 6. One bearded staff member was serving food on the tray line without a beard cover. These observations were made in the presence of Employee #28 who acknowledged the findings.	F 371	Food Services Director has conducted environmental rounds to identify and correct any deficient practice. 3. To prevent future occurrences the Food Service Director/designee will conduct monthly environmental rounds and document findings. Performance will be reported to the quarterly Quality Assurance committee meeting. QAC will ensure oversight and corrections of any identified deficiencies. 4. Responsible Individual: Food Service Director	2/9/16
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review of one (1) of 47 Stage 2 sampled residents, it was determined that the physician failed to include in the total plan of care, the rationale related to prescribing a nicotine patch outside of the manufacturer ' s recommendations for Resident #44. The findings include: The physician failed to include in the total plan of care, the rationale related to prescribing the nicotine patch outside of the manufacturer ' s recommendations for Resident #44. Manufacturer ' s Fact Sheet stipulated the following: Clear Nicotine Transdermal System Patch 14 mg delivered over 24 hours - Stop Smoking Aide. Warnings: when using this product do not smoke even when not wearing patch. The nicotine in your skin will still be entering your bloodstream for several hours after you take it off..." A review of the clinical record revealed a History and Physical examination signed by the physician October 1, 2015 that revealed Resident #44 is a smoker with diagnoses that included, Hypertension, Diabetes, Coronary Artery Disease, and CVA (Cerebrovascular accident) with left hemiplegia. Resident #44 was observed smoking in front of the main entrance of the facility on Wednesday,	F 386	1. The physician's order for a nicotine patch for resident #44 has been discontinued. 2. The medical records of all residents with nicotine patches have been reviewed to ensure the risks and benefits of smoking while wearing the patch, have been explained to each resident and/or/ responsible party. Any identified issues were corrected. 3. All licensed staff will be in-serviced on residents rights. (i.e., risk and benefits of treatments) 4. To prevent future occurrences, the Clinical Manager/designee will audit physician orders and care plans, to ensure risk/benefit for medications have been addressed. Results of audits will be forwarded to the DON and presented at the quarterly Quality Assurance Committee meeting. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 36 November 4, 2015 at approximately 5:00 PM. During a medication pass observation on November 5, 2015 at 10:15 AM the nurse was observed applying a Clear Nicotine Transdermal patch to Resident#44 ' s skin. There was no evidence that the physician included, in Resident #44 ' s total plan of care, the rationale related to prescribing the nicotine patch outside of the manufacturer ' s recommendations. The record revealed that the physician was aware of the resident ' s smoking activities. The clinical record lacked evidence that Resident #44 was provided information related to the risks and benefits of smoking while wearing the nicotine transdermal patch prior to the initiation of treatment. A face-to-face interview was conducted with the Medical Director on November 6, 2015 at approximately 9:00 AM. When informed of manufacturer ' s recommendations regarding risks and benefits and that Resident # 44 has been observed smoking on multiple occasions during survey. He/she stated, "I am aware of manufacturer recommendations but feel the potential benefits outweigh the risks". When queried if risks and benefits were explained to resident and/or responsible party, he /she stated they were not. He/she acknowledged the aforementioned findings. The clinical record was reviewed on November 5, 2015.	F 386		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/09/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 37 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made on November 4, 2015 at approximately 10:00 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen in dietary services during a tour of the main kitchen. The findings include: Flying insects were observed in the main kitchen area on November 4, 2015 at approximately 10:00 AM. These observations were made in the presence of Employee #28 who acknowledged the findings.	F 469	The Facility pest control company has sprayed for insect elimination. All drains and trash cans and drains have been cleaned. To prevent future occurrences the Food Services Director will conduct weekly rounds to identify and correct deficiencies. Performance will be reported to the quarterly Quality Assurance meeting. Responsible Individual: Director of Food Services.	2/9/16