STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING 7W - UNITED MEDICAL NURSING CENTER B. WING _____	12/22/2015

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

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K 000	INITIAL COMMENTS The following findings are based on observations and staff interview during the Life Safety Code survey conducted on December 22, 2015.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that resident entrance doors were impeded from closing when bathroom doors were in the open position and resident and common area doors were observed to be held open with props, which would prevent doors from closing and not impede the spread of smoke in the event of a fire in four (4) of 14	K 018	Please begin typing here....	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda C Quillen | TITLE: Interim Administrator | (X6) DATE: 1/15/16

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.

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K 018	Continued From page 1 observations. These findings were observed in the presence of the Director of Engineering. The findings include: A. Entrance doors were improperly held open with props in three (3) of 14 observations between 11:50 AM and 12:30 PM on December 22, 2015 as follows: 1. Entrance doors to resident rooms 702 and 703 were improperly held open with trash cans. 2. The east side entrance door to the 7th Floor Day Room was improperly held open with a trash can. The trash cans would prevent the doors from closing which would not impede the passage of smoke in the event of a fire. NFPA 18.3.63 B. In one (1) of 14 observations, an entrance door was impeded from closing as follows: 1. The entrance door to resident room 702 failed to close when the bathroom door was in the open position when tested. The failure of the door to close would not impede the passage of smoke in the event of a fire. NFPA 18.3.63 The observations were made between 11:50 AM 12:30 PM on December 22, 2015 in the presence of the Director of Engineering.	K 018	1. Props were removed from entrance doors. • Trash cans were removed from entrance doors to resident's rooms 702 and 703. • Trash can was removed from the east side entrance door to the 7th floor. • Entrance door to resident room 702 has been repaired. 2. The facility was inspected by the environmental team. All deficient areas were corrected. 3. Staff education will be conducted to prevent future non-compliance. 4. Weekly environmental rounds will be conducted to prevent future non-compliance related to resident environmental safety. Any deficient practice related to resident safety 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 individuals: Administrator	2/9/16
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		

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K 025	Continued From page 2 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that penetrations were observed in smoke barrier walls above double doors which would not prohibit the passage of smoke in the event of a fire. These findings were observed in the presence of the Director of Engineering. The findings include: Penetrations approximately 7 " X 14 inches in size were observed around ceiling tiles and conduit pipes that penetrate through the upper wall above the Fire Control Panel in the Fire Room in eight (8) of eight (8) observations at 3:30 PM on December 22, 2015.	K 025	1. The ceiling penetrations were repaired. 2. The entire facility was inspected during weekly environmental rounds. Any deficient practice found was corrected. 3. To prevent future occurrences, ceiling penetrations will be monitored during weekly environmental rounds for 3 months and findings documented by the Director Facilities Management/designee. Performance will be reported to the quarterly Quality Assurance Committee meeting. 4. Responsible Individual: Director of Facilities Management	2/9/16
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050		

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K 050	Continued From page 3 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations during the Pull Station Test on the seventh floor it was determined that facility staff failed to respond to the Fire Alarm in a timely manner. Doors to resident rooms were left open and equipment remained in the hallway during the test drill one (1) of three (3) observations. The findings include: During the pull station test that was initiated on the east side hallway of the 7th floor at 3:20 PM on December 22, 2015, it was determined that staff failed to close doors and move equipment from the hallways on the west side in one (1) of two (2) observations. At 3:25 PM, approximately 5 minutes into the pull station test, equipment remained in the corridor and resident room doors were observed open. There was no evidence that staff were in the process of closing the doors or removing the equipment. A failure to close doors and remove equipment from the hallways following the initiation of a fire alarm could potentially be hazardous to residents and staff in the event of a fire.	K 050	1. All staff were counseled on appropriate responses to fire alarms. 2. Rounds were made by the Clinical Managers and ADON to ensure that all equipment was removed from hallways. 3. To prevent future occurrences, staff reeducation will be conducted. 4. Staff response to fire alarms will be monitored for 3 months. Any deficient practice will be immediately reported to the Administrator and addressed with staff for immediate correction. It will also be reported to the QA committee. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible person: Administrator	2/9/16
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

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K 062	Continued From page 4 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that sprinkler heads were not maintained to ensure proper operation in the event of a fire as evidenced by accumulated paint on sprinkler head surfaces in eight (8) of 12 observations and sprinklers heads were installed less than 12 inches from the shower curtains which would impede the flow of water in the event of an emergency in the Shower Room in seven three (3) of eight (8) observations at 11:40 AM. These findings were observed in the presence of the Director of Engineering. The findings include: A. During a Life Safety Code tour of the facility it was determined that sprinklers were soiled with paint on the head surfaces which could potentially affect the operation of sprinklers in the 6th and 7th Floor Laundry Rooms in two (2) of two (2) observations and two (2) of five (5) observations of sprinklers in the hallway near Rooms 612 and 613 between 3:10 PM and 3:30 on December 22, 2015. 1. Paint was observed on sprinkler head surfaces in the 7th Shower Room in two (2) of three (3) observations and in the hallway near Stairwell #2 in two (2) of two (2) observations at 12:20 PM on December 22, 2015. The paint on the surfaces of the sprinklers could potentially adversely affect their ability to operate effectively	K 062	Work order for removal of paint on sprinklers head has been generated.	1/22/16

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K 062	Continued From page 5 in the event of a fire emergency. B. Sprinkler heads were installed less than 12 inches from shower curtains and curtain rods in the 6th Floor Shower Room in three (3) of eight (8) observations at 11: 30 AM on December 22, 2015. This could impede the flow of water from sprinklers in the event of a fire emergency. The observations were made in the presence of the Director of Engineering on December 22, 2015.	K 062	Issue is being investigated and work order has been placed.	4/15/16
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that a landing outside of the boiler room lacked the necessary handrails to prevent accidental falls and slips when exiting the Boiler Room. This finding was observed in the presence of Maintenance and Boiler Room Staff. The findings include: A cement landing located outside of the Boiler room exit door approximately four (4) feet from the ground in height with steps, lacked a guardrail and/or handrail(s) to help staff gain support as they exit the Boiler Room. The current arrangement can contribute to slips or falls resulting in serious injury when exiting the Boiler Room near the Emergency Generator and the Parking Area in one of one (1) observation at 3:45 PM on December 22, 2015.	K 130	Guard rails were recently stolen and new one have been ordered and being manufactured.	3/30/16

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	Continued From page 6			
K 130	NFPA 101 LIFE SAFETY CODE STANDARD	K 130	Documentation was completed to prevent future occurrences.	
K 144 SS=E	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Survey, it was determined that the Remote Annunciator Panel was not installed in the Security Office to determine the status of Emergency Generator operation in the event of an emergency. Additionally, the Alarm Annunciator Panel in the Boiler Room Office failed to display pertinent digital information about the generator status during emergency operation in two (2) of (2) observations. These findings were observed in the presence of the Director of Engineering. The findings include: During the Life Safety Code Inspection, in two (2) of two (2) observations between 3:45 PM and 3:55 PM on December 22, 2015, it was determined that the Remote Annunciator Panel was not installed in the Security Station, to provide digital updates on the operation of the Emergency Generator during an outage. The Alarm Annunciator Panel in the Boiler Room Office failed to display pertinent digital information about the generator status during emergency operation. NFPA99, Standard for Health Care Facilities, 2005 Edition 4.4.1.1.17	K 144	Documentation will be completed in a clear manner. Issues was resolved.	1/8/16 12/31/15

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K 144	Continued From page 7	K 144		