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

PRINTED: 02/18/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCFD020030	A. BUILDING _____ B. WING _____	02/13/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F309	
	An initial certification survey was conducted on February 13, 2009. The following deficiencies are based on record review, observations, and interviews. The sample and facility census was four (4) residents.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident was assessed, the blood glucose levels were checked and found to be within normal limits. The resident was not affected by the deficient practice.	02/26/09
F 309 SS=D	483.25 QUALITY OF CARE 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 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of four (4) sampled residents, it was determined that facility staff failed to administer insulin in accordance with the sliding scale order for Resident #3. The findings include: Facility staff failed to administer insulin in accordance with the sliding scale order for Resident #3. A review of the February 2009 Medication Administration Record [MAR] revealed an order that directed, " Monitor blood glucose via finger stick A.C. [before] b ' fast [breakfast], lunch, and dinner, and H.S. [hour of sleep], sliding scale of insulin [brand name] Novolog [for Diabetes Mellitus] as follows, 121-199 -1 u [give one unit] ... " .	F 309	**2. How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit was conducted for all other resident's receiving insulin. No other resident was found to be affected by the deficient practice. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An audit tool was created and implemented for all residents receiving insulin. Initially the tool will be used per shift for 30 days. If no deficient practice found we will monitor monthly. All staff educated on proper administration of insulin, hyperglycemic reaction, and proper documentation. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be in place?** Audit tool will be presented by ADON at monthly QA meetings. QA Nurse will track, trend and follow-up.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rene Marie Cell	Administrator	2/28/09

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
	HCFD020030		02/13/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 According to the MAR Resident #3 ' s blood sugar result was 101 and Novolog 1 unit was administered at 6:30 PM on February 12, 2009. Per the sliding scale the facility staff should not have administered Novolog insulin when the blood sugar level was 101. The Resident #3 had no untoward affects noted. A face-to-face interview was conducted with the Assistant Director of Nursing on February 13, 2009 at approximately 4:30 PM. He/She acknowledged that the insulin was not given in accordance with the sliding scale. The record was reviewed February 13, 2009.	F 309	F441 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident will remain on isolation with all appropriate set up until the order is discontinued by a physician. **2. How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other residents were reviewed and no other resident was on isolation precautions. No other resident was affected by this deficient practice.	02/26/09
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined that facility staff failed to follow the facility's infection control program by not writing an order to discontinue contact isolation for one (1) of four (4) sampled residents. Resident # 1	F 441	**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An audit tool created to monitor all residents on isolation per shift for 30 days. Staff was educated on infection control surveillance, and UMNC infection control policy. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be in place?** ADON will track and trend the audit tool at the monthly QA meeting and report all findings to the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HCFD020030		02/13/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 2 The findings include: Facility staff failed to document the discontinuance of contact isolation for Resident #1 that had a diagnosis of Vancomycin Resistant Enterococci (VRE) in accordance with the facility's policy entitled "Policy for Isolation (page E-2) ". Policy for Isolation states: "...The above isolation [Airborne, Droplet, and Contact] precautions may be instituted by a physician, the Infection Control Professional, the Director of Nurses, the Assistant Director of Nurses, the Nursing Supervisor and the Charge Nurse and may be discontinued only by one of the above ". A review of Resident #1's Physician's order dated February 4, 2009 at 9:05 AM directed, "Maintain on contact isolation for VRE [vancomycin-resistant enterococci] of stool ..." During tour of the facility on February 13, 2009, at 3:05 PM Resident 1's room was observed to have a contact isolation sign posted on the entry door; however, there was no personal protective equipment [PPE] available for staff and /or visitor application. A face-to-face interview was conducted with the Assistant Director of Nursing on February 13, 2009, at approximately 4:30 PM. He/She stated, "Resident #1 is off of isolation, he/she [resident] has not had any loose stools. We removed the PPE. When queried as to the results of the negative cultures and the documented evidence to discontinue the contact isolation. Employee #2	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HCFD020030		02/13/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 3 Stated, "We don't have them." There was no evidence in the record that discontinuance of contact isolation was conducted by an authorized professional in accordance with the facility's policy, prior to facility staff removing the PPE from outside the resident ' s room. The record was reviewed February 13, 2009.	F 441	F454 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The wedge was removed immediately on 2/13/09 and the door was closed. No resident was affected by the deficient practice.	02/26/09
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation during the survey conducted on February 13, 2009, it was determined that facility staff failed to maintain fire safety as evidenced by propping open an entry door to the day room. The findings include: NFPA 101, [K18] 19.3.6.3.3* stipulates: "Hold - open devices that release when the door is pushed or pulled shall be permitted". During the survey on February 13, 2009 at approximately 4:50 PM, it was observed that the entry door to the resident's day room was propped open with a rubber wedge. The wedge did not release when the surveyor pulled on the door. This observation was made in the presence of Assistant Director of Nursing who acknowledged	F 454	**2. How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other doors were checked in nursing center and no other doors were found propped open. No other resident was affected by this deficient practice. **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** A QA tool was put in place for tracking this deficiency. The hospital staff and nursing center staff were all educated about propping of doors. All staff were mandated to be vigilant about seeing any doors propped open. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be in place?** The deficient practice will be monitored at the monthly quality assurance meeting, tracking and trending will also occur by QA Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HCFD020030		02/13/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 454	Continued From page 4 the finding at the time of the observation.	F 454		