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	095036	A. BUILDING _____ B. WING _____	04/04/2011

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UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

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F 000	INITIAL COMMENTS A recertification survey was conducted on March 28 to April 4, 2011. The following deficiencies were based on observations, record review and resident and staff interviews for 28 sampled residents.	F 000	Unique Residential Care Center makes its best efforts to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the Statement of Deficiencies. This Plan of correction (POC) is prepared and/or executed solely because it is required by Federal and State Laws.	
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 observations, record review and staff interviews three (3) of 28 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches for the potential adverse effects of the use of nine (9) or	F 279	1. Resident #71 was immediately provided oral hygiene. Resident #71 was also reassessed and the care plan was updated to include Oral hygiene, hydration and nine or more medications. Resident #114 was reassessed and the care plan was revised to include fluid restriction amounts. Resident #163 had a care plan for 9 or more medications; however staff had not printed it from the computer at the time of survey. Care Plan has been printed and is currently in medical record. 2. A list was obtained from pharmacy to identify residents with 9 or more medications. The care plan was reviewed for these residents; no other resident was identified to be impacted by the practice. A review of the ADL needs and fluid needs of the residents was conducted. No other resident was impacted by this practice. 3. The IDT team members were re-educated regarding the care planning needs of the resident. 4. Monitoring the care plan is completed monthly by the nursing management team. This information is reported to the QI committee quarterly.	5/2/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rachel Wren VMT VP of Quality/Administrator 4/22/11

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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F 279	Continued From page 1 more medications for two (2) residents, oral hygiene for one (1) resident; dehydration for one (1) resident, and fluid restriction for one (1) resident. Residents #71, #114, and #163. The findings include: 1a. Facility staff failed to develop a comprehensive care plan with goals and approaches to address oral hygiene care for Resident #71. A review of an admission MDS [Minimum Data Set] dated January 3, 2011 under Section G -Functional Status [G0110] -J was checked and indicated " Personal hygiene- how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands. Resident #71 was coded as requiring extensive assistance with his/her personal hygiene." The Care Assessment Area dated January 3, 2011 revealed that ADL [Activities of Daily Living] was triggered/checked for care planning. The Care Plan section of the current clinical record contained a Care Plan initiated 01/03/2011 [January 3, 2011] that revealed, " Problem: Resident is limited in ability to maintain grooming/personal hygiene [related to] Dementia. Goal: Resident will be well groomed. Approach: Provide full staff performance for grooming hair _____ (frequency) [No frequency indicated and the space was left blank]." The care plan indicated no goals and interventions for oral hygiene.	F 279		

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F 279	Continued From page 2 Resident #71 was observed March 29, 2011 at approximately 1:00 PM. His/her lips were dry and cracked with white matter around outer mouth. A face to face interview was conducted on March 30, 2011 at approximately 1:30 PM with Employee # 8 regarding resident's mouth care. He/she acknowledged that the care plan did not include goals and approaches for oral hygiene [mouth care]. The clinical record was reviewed on March 30, 2011. 1b. Facility staff failed to develop a comprehensive care plan with goals and approaches to address the dehydration/fluid maintenance status for Resident # 71. A review of the admission MDS [Minimum Data Set] dated 01/03/2011 revealed in Section I -Active Diagnoses (Active Diagnoses in the last 7 days) I12300 was checked indicating "Urinary Tract Infection (UTI) (Last 30 days). " This Care Assessment Area triggered for Care planning. The "Summary Notes " for dehydration/fluid maintenance revealed, "Resident has poor p.o. [by mouth] intake and refuse oral fluids when offered by staff as per ordered. Staff will monitor labs and skin for s/s [signs and symptoms] of dehydration and notify MD. No nausea or vomiting or constipation noted. Resident is not on any diuretics but is taking ABT [antibiotics] for UTI [Urinary tract infection]. Care plan decision addressed in care plan. " The Care Plan section of the record contained a care plan initiated 01/04/2011 [January 4, 2011] No problem and goals/ interventions were identified on the care plan for dehydration/fluid	F 279		

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F 279	Continued From page 3 maintenance. A face-to-face interview was conducted on March 30, 2011 at approximately 2:30 PM with Employee #8 regarding a problem not initiated for dehydration/fluid maintenance with goals and interventions on the care plan. He/she acknowledged that a care plan had not been developed for dehydration/fluid maintenance for the aforementioned resident. The record was reviewed on March 30, 2011. 1c. Facility staff failed to initiate a care plan with goals and approaches for potential/actual adverse drug interaction for nine (9) or more medications for Resident #71. A review of Resident #71 ' s record revealed physician ' s orders dated and signed January 31, 2011 for 11 medications. The medications were as follows: Remeron 30 mg (Schizophrenia), Haldol 2mg (Schizophrenia), Cogentin 0.5mg (Parkinson), Caltrate with Vitamon D (Supplement), Aricept 10mg (Dementia), (Folic Acid 1mg (Anemia), Geodon 40mg (Schizophrenia), Lisinopril 10mg (Hypertension), Tapazole 5mg (Hyperthyroidism), Lopressor 25mg (hypertension), and Tylenol 325mg PRN for Pain. A review of the care plan initiated on January 4, 2011, failed to include a plan of care for potential/actual adverse drug interaction for the 9 medications. A face-to-face interview was conducted with Employee #8 on March 30, 2011 at approximately 2:30 PM. He/she acknowledged that a care plan had not been developed for nine	F 279		

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F 279	Continued From page 4 (9) or more medications for the aforementioned resident. The record was reviewed on March 30, 2011. 2. Facility staff failed to develop a care plan for Resident #114 on fluid restriction. A review of Resident #114 record revealed that he/she had a diagnosis of Acute COPD [chronic obstructive pulmonary disease]. The physician ' s order dated March 15, 2011 at 7:00 PM directed, " ...4)Fluid restriction to 1 [one] liter each 24 hours ... " A review of the Medication Administration Record for March 2011 revealed that 200 mls of fluids were to be given on the 11-7 shift, 500 mls of fluid were to be given on 7-3 shift and 300 mls of fluids were to be given on the 3-11 shift. A review of the care plan section of the active clinical record was reviewed. There was no evidence that a care plan was developed with goals and approaches to address the resident ' s fluid restriction. A face-to-face interview was conducted with Employee #11 on April 4, 2011 at approximately 12:00 PM. He/she acknowledged that a care plan was developed to address the resident ' s fluid restriction. The record was reviewed on April 4, 2011. 3. Facility staff failed to initiate a comprehensive care plan with appropriate goals and approaches for the potential adverse effects of the use of 9 or more medications for Resident #163 who receives13 medications. A review of the clinical record revealed that Resident #163 was admitted to the facility on December 22, 2011. A review of the Physician ' s Order Sheet on the clinical record which was	F 279		

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F 279	Continued From page 5 dated December 18, 2011 and signed February 26, 2011 revealed medications, which included Amlodipine, Docusate, Donezipil, Folic Acid, Levothyroxine, Mirtazapine, Multivitamin, Omeprazole, Polyethylene Glycol, Tamsulosin, Thiamine Xalatan Opth [Opthalmic) and Acetaminophen. A review of the comprehensive care plans on the record which were initiated on December 23, 2010 and reviewed on March 23, 2010 revealed that no care plan was initiated with goals and approaches for the potential adverse effects of the use of nine [9] or more medications for the resident. A face-to-face interview was conducted with Employee #7 at approximately 10:30 AM on March 31, 2011. During the interview the employee reviewed the care plans and acknowledged that the record lacked a care plan for the use of nine [9] or more medications. He/she stated, " I will put one on the record. " The record was reviewed on March 31, 2011. The facility staff failed to initiate a care plan with goals and approaches for the potential adverse effects of the use of nine [9] or more medications.	F 279		
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 and plan of care.	F 309		

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviewed for one (1) of 28 residents, it was determined that the facility staff failed to clarify the Psychiatrist's evaluation to continue Resident #181 on Zoloft for Depression. The findings include: An Interim Order dated August 28, 2010 [no time indicated] directed, " D/C (discontinue) Zoloft 50 mg one tablet PO QD (every day). Decrease Zoloft 25 mg PO QD times 30 days then D/C. " The Medication Administration Record for August 2010, revealed that Zoloft 50 mg one tablet by mouth for depression was discontinued on August 28, 2010. Zoloft 25 mg one tablet PO daily times 30 days for depression was started and administered on August 29, 2011. The Medication Administration Record for September 2010, revealed that Zoloft 25 mg PO one tablet times 30 days for depression was discontinued on September 28, 2010. A review of clinical record revealed a Psychiatrist progress note dated September 14, 2010 that revealed, "Psych evaluation and medication review done Notes dictated. Full notes ... will follow. " According to Employee #9 the following Psychiatrist Evaluation notes dated September 14, 2010 and was faxed to facility [from the psychiatrist] directed, " Recommendations/Plan: Continue medication at present doses. " The medication listed on consult was "Setraline (Zoloft) 50 mg PO (by mouth) daily for	F 309	1. A review of resident #181 was completed. The nursing staff followed the orders of the physician extender, behavior systems were monitored and no signs/symptoms of depression notified. The psychiatrist was contacted and clarification of the order was received. 2. A review of resident on Zoloft was completed no other resident was found to be impacted by this practice. 3. The nursing staff were re-educated regarding physicians orders and a discussion was held with the Medical Director and Psychiatrist regarding clarification of orders. 4. Monitoring the physician orders and documentation in the record is done monthly and reported to the QI committee quarterly.	5/2/11

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F 309	Continued From page 7 Depression." A review of the nurses ' and physician progress notes from September 14, 2010 to March 31, 2011 revealed that there was no progress note in the clinical record that clarified Psychiatrist Evaluation dated September 14, 2010. The record lacked evidence that facility staff clarified the Psychiatrist evaluation to continue Resident #181 on Zoloft 50 mg for Depression. A face-to-face interview was conducted on March 31, 2011 at 9:50 AM with Employee #9. He/ she acknowledged the aforementioned findings. The record was reviewed	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 28 sampled residents, it was determined that facility staff failed to document: the activity of daily living (ADL) on the ADL flow sheet for one (1) resident; voiced concerns	F 514	1. A review of the resident #181 was done. Resident was receiving the care, unable to retrospectively correct documentation. Staff was reminded to document care provided. Resident #209's documentation was updated to reflect residents concerns, report submitted as required and resident was advised of the status. Resident #235 was seen by dentist, cleaning and assessment was conducted, prior medical authorization was submitted. Resident and and Responsible Party were updated on the status. 2. A review of documentation was done, unable to retrospectively correct from prior timer period, but re-enforcement of documentation has been done. A special luncheon meeting was held with the Resident Council Officers and unit representatives no other resident voiced any concerns. 3. Meeting conducted with staff, a detailed review of documentation requirements, including documentation updates of resident concerns. Meeting held with social worker and dentist regarding ensuring documentation of care is done. 4. Monitoring documentation in the closed record is conducted monthly by members of the clinical team and medical records staff. This information is reported quarterly to the QI Committee.	5/2/11

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F 514	Continued From page 8 regarding missing money for one (1) resident; and the status of a request for dentures for one (1) resident. The findings include: 1. Facility staff failed to consistently document Resident # 181 ' s activity of daily living (ADL) on the ADL flow sheet for March 2011. A review of the March 2011 ADL flow sheet on April 1, 2011 revealed that facility staff throughout the month of March did not consistently document the resident ' s activity for sleep, bathing, shampoo, nail care, AM and PM care, meal intake, bladder and bowel as scheduled on the night, day and evening shift on the ADL flow sheet. The record lacked evidence that facility staff consistently documented the resident ' s ADL activity on the flow sheet for March 2011. A face-to-face interview was conducted with Employee #5 on April 1, 2011 at 10:00 AM. He/she acknowledged that facility staff failed to consistently document the resident ' s activity on the ADL flow sheet for March 2011. The record was reviewed April 1, 2011. 2. Facility staff failed to document Resident #209's "voiced concern " regarding missing money. A face-to-face interview was conducted on March 29, 2011 at approximately 11:00 AM with Resident #209. When the resident was queried, " Have you had any missing personal items, such as clothing, jewelry, a radio, money, etc. and	F 514		

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his/her response was , " Yes, three (3) weeks ago ten dollars was missing out of my pocketbook. I reported it and it is still missing. "

A face-to-face interview was conducted with Employee #8 on April 1, 2011 at approximately 3:30 PM regarding resident ' s missing money. He/she responded, " I was not aware of missing money. I will ask the Social Worker to intervene. "

A face-to-face interview was conducted with Employee #16 on April 4, 2011 at approximately 10:00 AM. He/she stated, "Resident #209 reported to him/her two (2) weeks ago, that he/she was missing ten dollars ($10.00) from his/her purse. The engineer department was informed and a lock was requested to be placed on Resident #209's closet so he/she could secure his/her possessions in the future. The engineering department informed security."

The " Security Incident Report Form" , signed and dated March 18, 2011 revealed, " Employee #17 of the engineering department informed Employee #18 of missing money $10.00 [ten dollars] from resident [Resident #209]. Security and CNA's [Certified Nursing Assistant's] searched the room but did not find the missing $10.00. Laundry was then notified to check all soiled linen from 3 North. They also did not find any money."

The clinical record lacked documentation that Resident #209 voiced a concern regarding money that was missing from his/her pocketbook.

A face-to-face interview was conducted with

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Employees #8 and #16 on April 4, 2011 at approximately 10:30 AM. They both acknowledged that there was no documentation in the record regarding missing money for Resident #209. The record was reviewed on April 4, 2011.

3. Facility staff failed to document the status of the Resident #235's request for dentures.
A family interview was conducted with Resident #235 ' s family member/responsible party [RP] at approximately 2:30 PM on March 29, 2011. During the interview the RP informed the surveyor that his/her father/mother needed new dentures. According to the RP the facility was notified verbally by his/her father/mother of the need for the dentures [RP was not sure of date].
A face-to-face interview was conducted with Resident #235 at approximately 10:30 AM on April 4, 2011. During the interview the resident informed this surveyor that, "The upper/lower dentures old, don't fit well and cause difficulty when I eat. " The resident was queried whether he/she had informed the staff of the problem. " He/she stated " Yes, [name] Employee #16. " The resident continued, " They cleaned my teeth but that ' s all. Nobody told me anything about the dentures. " The resident was unable to tell this surveyor when he/she informed the facility ' s staff of his/her need for new dentures.
A face-to-face interview was conducted with Employees #7 and #8 simultaneously at approximately 10:40 AM on April 4, 2011. Both employees denied any knowledge of the resident ' s need for new dentures.
A face-to-face interview was also conducted with Employee #16 at approximately 10:45 AM on April 4, 2011. The employee was queried whether he/she was aware of the resident ' s

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request for new dentures. He/she acknowledged receiving a verbal request from the resident for new dentures. He/she stated, " I think it was a few weeks ago that he/she [the resident] asked for some new dentures. I told the dentist and I believe that he/she [the dentist] saw him/her [the resident] last week. " The employee was then queried further regarding the status of the dentures and whether the nursing staff was aware of the resident's request for new dentures. Employee #16 responded, " I only told the dentist. I figured he/she would take care of it. I will call him/her to find out the status of the dentures. " At approximately 11:00 AM Employee #16 informed this surveyor that the dentist had seen the resident and stated, " I will put a note in the chart. " In response to a query regarding whether the request and/or status of the dentures was documented in the resident' s record, Employee #16 responded, " No, I did not write anything in the record. "
A review of the documentation in the resident' s clinical record revealed no documentation of the resident ' s request/need for new dentures and no documentation of anyone discussing the dentures/progress of the dentures with the resident and/or family member/RP. A review of the dental documentation in the record revealed two notations. The first was dated January 6, 2011, [oral evaluation/oral cancer screening]. The second was dated March 20, 2011 and discussed poor oral assessment, inflamed tissue and heavy plaques.

On April 4, 2011 after the interview with this surveyor Employee #16 documented the following information in the resident ' s record. " Resident reported he/she needs to replace his/her dentures. He/she was seen by dentist on

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UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

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F 514	Continued From page 12 3/20/11 for cleaning. Dentist submitted request to Medicaid for dentures on 3/23/11. Dentist is awaiting authorization." Additionally, Employee #1 provided a " Prior Authorization Request Approval " form signed by the dentist on February 23, 2011 for " Peridontal Scaling and Root Planning and Study Models. A second form was signed on March 23, 2011 that clarified that the study models were for (dentures). The aforementioned documents were faxed to the facility from the dentist's office at approximately 3:50 PM on April 4, 2011. The record was reviewed on April 1, 2011. Facility staff failed to document the resident ' s request/need for new dentures on the resident's clinical record.	F 514		