

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/18/2023
NAME OF PROVIDER OR SUPPLIER UNIQUE REHABILITATION AND HEALTH CENTER LL		STREET ADDRESS, CITY, STATE, ZIP CODE 901 FIRST STREET NW WASHINGTON, DC 20001		
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{L 000}	<p>Initial Comments</p> <p>An unannounced onsite revisit survey was conducted at this facility on January 18, 2023 as a follow up to the recertification survey of September 26, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 209 and the survey sample included 12 residents.</p> <p>After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue DI- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)</p>	{L 000}	<p>Unique Rehabilitation and Health Center LLC 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 on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{L 000}	Continued From page 1 F - Fahrenheit FR - French G-tube - Gastrostomy tube HR - Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN - midnight N/C - nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician 's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse	{L 000}		

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{L 000}	Continued From page 2 ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	{L 000}		
{L 206}	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, facility staff failed to reconcile and account for controlled medications accurately and failed to account for the usage, administration, and reconciliation of Lorazepam 0.5 mg (medication used to treat anxiety and sleeping problems) tablets remaining for Resident #1. This was evident for on four (4) of eight (8) medication carts. The findings included: Review of the facility's Plan of Correction with a compliance date of 01/09/23 documented, "education was completed by the Staff Educator/Designee for all licensed nurses on 1/1/23 for ...ensuring appropriate narcotic counts at the start and end of the shift with appropriate documentation of narcotics ..."	{L 206}	F755 1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS Employee #3 was educated on 1/18/23 by the Staff Educator on safely storing, logging in the narcotic log and that documenting on the narcotic sheet should be immediately once the medication is administered. Corrective action was taken to ensure that the medication Lorazepam 0.5mg for Resident#1 was entered by Employee#3 and the narcotic sheet was reconciled on 1/18/23. No resident was affected due to this deficient practice.	

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{L 206}	<p>Continued From page 3</p> <p>1. Facility staff failed to ensure that two licensed nurses verified and signed that the Controlled Drug count was correct for each shift in the narcotic count books for medication carts located on units 1 North, 2 North, and 2 South.</p> <p>A review of the January 2023 Reconciliation Controlled Count Verification Form located on the medication carts were as follows:</p> <p>*1 North: 01/14/23 at 11:30 (night) shift showed the signature of the same licensed nurse for the oncoming and going off shifts.</p> <p>*2 North: 01/14/23, 3:00 PM (evening) shift was left blank.</p> <p>*2 South: the following dates showed the signature of the same license nurse for the oncoming and going off shifts</p> <p>-01/09/23, 7:00 AM (day) shift,</p> <p>-01/12/23, 3:00 AM (evening) shift,</p> <p>-01/13/23, 7:00 AM (day) shift and 11:00 PM (night) shift,</p> <p>-01/14/23, 3:00 PM (evening) shift,</p> <p>-01/15/23, 3:00 PM (evening) shift,</p> <p>During a face-to-face interview on 01/18/23 at approximately 4:00 PM, Employee #2 (Director of Nursing) reviewed and copied the documents and acknowledged that the signatures were missing, and the nurses' signature was the same for oncoming and off going shifts.</p> <p>2. Facility staff failed to account for the administration and reconciliation of Lorazepam 0.5mg (medication used to treat anxiety and sleeping problems) tablets remaining for Resident #1.</p> <p>On 01/18/23 at approximately 2:20 PM an observation of the controlled drug count for unit 3</p>	{L 206}	<p>2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED</p> <p>A house-wide audit was completed by Unit Managers on 1/18/23 for all medication carts to ensure Narcotics sheets are updated timely and reconciled by 2 nurses at the end of the shift. The deficient practice to ensure that 2 licensed nurses must verify and sign in the instance that the nurse works a double shift cannot be retroactively corrected. No residents were affected by this deficient practice.</p> <p>3. MEASURE TO PREVENT REOCCURENCE</p> <p>Education was completed on 1/27/2023 by the Staff Educator/designee for all licensed nurses to ensure that two nurses reconcile the narcotic count at the end of each shift and that narcotic will be documented in the narcotic sheet as soon as the medication is administered.</p> <p>4. MONITORING CORRECTIVE ACTION</p> <p>Unit Managers will audit their respective units to ensure narcotics administered are accurately reconciled at the end of each shift by two nurses and documented in the narcotic sheet promptly after administration. This audit will be done weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery.</p> <p>Date of Compliance: 01/27/2023</p>	

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{L 206}	<p>Continued From page 4</p> <p>South was conducted in the presence of Employee #3 (Registered Nurse).</p> <p>At this time, a blister pack of medication containing 12 tablets of Lorazepam 0.5 mg with Resident #1's name listed on the package was observed.</p> <p>Review of the "Controlled Drug Administration Record ..." form for Resident #1's Lorazepam 0.5 mg showed that on 1/17/23 at 6P (6:00 PM) there were "13" tablets of Lorazepam remaining. The next recorded entry showed the date/time "1/18/23 at 9 A (09:00 AM)", however the dose/amount administered by [Nurse signature] with the amount remaining was left blank.</p> <p>At the time of this observation Employee #3 stated, "I gave the medication this morning. I started to sign but I did not finish." Employee #3 pointed to the date and time recorded on 1/18/2023 at 09:00 AM.</p> <p>The evidence showed that facility staff failed to perform the reconciliation of narcotics on 01/18/2023 when the medication was administered to the resident.</p> <p>Cross reference DCMR F-755</p>	{L 206}		