STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	05/06/2015

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

(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 April 28 through May 6, 2015. The deficiencies are based on observation, record review, resident and staff interviews for 40 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMD - Antimicrobial Foam Dressings 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 DI - 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	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.	

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

Rowland Wren, DNP, RN-BC, CNHA VP/Administrator 7/2/15

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 000	Continued From page 1 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) 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 156 SS=D	483.10(b) (5) - (10), 483.10(b) (1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e) (6) of the Act. Such notification must be	F 156		

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F 156	Continued From page 2 made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which	F 156	**483.10(b) (1) Notice of Rights** **483.10(b)(1) Notice of Rights Rules, Service Charges** 1.URCC informed resident #226 of her/his rights on several occasions, however, resident refused to sign them. Met with resident and son and she agreed to let him sign the Admissions Agreement. Admission Agreement has been signed. 2. A review of all resident's admission agreement was conducted. Ensured that residents impacted by this were aware of their rights, rules and regulations governing residents conduct. 3. Admission Packet modified to include form for residents and/or Responsible Party who refused to sign documents after being informed of the rules and rights. For residents/Responsible Party who refuse admission staff will continue to have them signed, but will also inform social work staff who will attempt to get signatures. If refusal continues will document in record. 4. Monitoring Admission agreement is a component Of the QA/QI Program. Information is presented to the QA committee.	7/9/15

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F 156	Continued From page 3 cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to inform the resident at the time of admission of their rights, all rules and regulations governing resident conduct	F 156		

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F 156	Continued From page 4 and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, cost for service and changes in cost for services), as evidenced by failure to have residents sign the applicable admission forms. Resident #226 Facility staff failed to inform Resident #226 at the time of admission of their rights, all rules and regulations governing resident conduct and responsibilities. A review of the clinical record for Resident #226 was conducted. There was no evidence that forms related to the admissions process were signed indicating that the resident was informed of his/her Resident Rights. A face-to-face interview was conducted on May 6, 2015 at approximately 11:35 AM with Employee #16. After review of the above he/she acknowledged the findings. Facility staff failed to inform the resident at the time of admission of their rights, all rules and regulations governing resident conduct and responsibilities. The record was reviewed on May 4, 2015.	F 156		
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	F 272		

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F 272	Continued From page 5 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at 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 one (1) of 40 sampled residents, it was determined that facility staff failed to accurately code the admission Minimum Data Set (MDS) under Section O (Special Treatments,	F 272	**483.20(b) (1) Comprehensive – Assessments** 1. A review of resident # 194's clinical record was conducted. A modification for the MDS was completed. 2. A review of residents who were on the hospice program was conducted. No other residents was found to be impacted by this practice. 3. A meeting was conducted with nursing management and hospice provider. The staff were re-educated regarding section O of the MDS. 4. Monitoring the MDS is a component of the quality improvement program. Section O has been added to the monitoring tool. This information will be presented at the QA/QI committee meeting.	7/9/15

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F 272	Continued From page 6 Procedures, and Programs) for one (1) resident with a terminal diagnosis and received hospice care. Resident #194. The findings include: A review of Resident #194 ' s History and Physical revealed that he/she was admitted to facility with a diagnosis of metastatic bladder cancer into hospice care on December 18, 2014. A physician's order dated December 18, 2014 read as follows: "Admit to Hospice Svcs (Services) R/T (related to) Metastatic Bladder Cancer." A review of the resident ' s admission MDS with an Assessment Reference Date of December 23, 2014 revealed that under Section O the resident was not coded for receiving Hospice care. A face-to-face interview was conducted with Employee #15 at approximately 11:00 AM on May 5, 2015. After reviewing the MDS, the employee acknowledged that the MDS was not coded to reflect that the resident was receiving hospice care. The record was reviewed on May 5, 2014.	F 272		
F 309 SS=E	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 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to ensure that one (1) resident's Peripherally Inserted Central Catheter (PICC) line was flushed and monitored in accordance with the attending physician's order. Resident #226. The findings include: According to the facility ' s " Infusion and Procedure Manual, Corresponding Section: Overview of IV [Intravenous] Therapy " Effective Date: October 1, 2010 page six (6) of 31 stipulated ... " (d.) Peripherally Inserted Central Catheter (PICC) ...(9) Upper arm circumference should be measured on admission, and weekly to monitor for infiltration; (10) External catheter length should be monitored on admission, and weekly to monitor for outward migration of the catheter ... " 1a.Facility staff failed to flush a PICC line in accordance with the physician ' s orders for Resident #226. A review of the Admission Order Sheet and Physician Plan of Care dated April 21, 2015 directed: " Vancomycin 1 gm [gram] IV [Intravenous] daily X [times] 10 days for Pneumonia; Levaquin 500mg [milligrams] IV daily X 7 [seven] days for Pneumonia; Flush PICC line per protocol. " A review of the Central-Line Catheter Protocol for	F 309	**483.25 Provide Care/Services for Highest Well Being** 1A. 1. A review of the Medication Administration Record was conducted as it pertains to resident #226. Unable to retrospectively correct. The peripherally Inserted Central Catheter (PICC) line was subsequently discontinued. 2. A review of all residents, was conducted. No other resident had a PICC line. 3. The nursing Staff were re-educated regarding the flushing protocol for PICC lines. 4. Monitoring of documentation is a part of the QA/QI program and is presented in the QA/QI Committee meeting. **1B** 1. A review of the Medication Administration Record as it pertains to measurement of PICC line was conducted for resident #226. Unable to retrospectively correct. The PICC line was subsequently discontinued. An x-ray was done to ensure it was completely removed. 2. A review of the residents at URCC was conducted. No other resident was impacted by this practice. 3. The nursing staff were re-educated regarding monitoring and measuring the PICC line. 4. Monitoring of documentation is a part of the QA/QI Program and is presented in the QA/QI committee meeting.	7/9/15 7/9/15

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F 309	Continued From page 8 April 21, 2015 through May 1, 2015 revealed: " Flushing Protocol: Use at least 10ml (milliliter) barrel size syringe for all IV devices; Intermittent Infusion: closed ended (valved) catheters; 5 ml NS [Normal Saline] before infusion; 5 ml NS after infusion. PICC - flush all lumens Q [every] shift; closed ended (non-valved) catheters - Flush all lumens at least Q 24 hours. " The April 2015 and May 2015 Central - Catheters flow sheets and the MAR [Medication Administration Records] lacked evidence (spaces left blank) that facility staff flushed the resident's central line on April 28, 29, 30, 2015 and May 1, 2015. A face-to-face interview was conducted on May 1, 2015 with Employee #10 at approximately 10:30 AM. After review of the above he/she acknowledged the findings. The record was reviewed on May 1, 2015 1b. Facility staff failed to monitor Resident #226 ' s PICC line according to physician orders. A review of the Central-Line Catheters protocol for April 2015 and May 2015 directed: "Monitoring: PICC Catheters (record on MAR) Measure upper arm circumference 10 inches above insertion site on admission, Q [every] 5 [five] days (with dressing change); Measure external catheter length on admission, Q 5 days (with dressing change) and PRN [as needed] " A review of the Central-Line Catheters monitoring flow sheets, MAR and Nurses Notes from April 21, 2015 through May 1, 2015 lacked any evidence of measurements of the resident's	F 309		

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F 309	Continued From page 9 upper arm circumference or the external catheter length according to the facility's protocol. A face-to-face interview was conducted on May 1, 2015 with Employee #10 at approximately 10:30 AM. After a review of the above clinical record he/she acknowledged the aforementioned findings. The record was reviewed on May 1, 2015.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 admission sampled (Stage 1)residents, it was determined that facility staff failed to ensure that one (1) resident who entered the facility having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent a new pressure sore from developing. This was a closed record review. The findings include:	F 314	**483.25(c) Treatment/Svcs to Prevent/Heal Pressure Ulcers** 1. A review of the closed record for resident #64 was conducted. Resident did not develop a facility acquired pressure ulcer on the left buttock. This closed record does not provide a mechanism of retrospectively correcting. 2. A review of all residents with pressure ulcers was conducted. This included reviewing diagnosis, physicians records, nursing notes, skin sheets and of course the resident. No other resident was found to be impacted by this practice. 3.The nursing staff was re-educated regarding pressure ulcers and documentation including the use of skin sheets for monitoring each pressure ulcer. 4. A review of pressure ulcers and documentation is conducted weekly. This documentation /audit is presented to the DON/ADON. This information is presented to the QA/QI committee.	7/9/15

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F 314	Continued From page 10 Facility staff failed to consistently assess Resident #64 ' s skin integrity to prevent a facility acquired pressure ulcer on the left buttock. Subsequently, a Stage 3 pressure ulcer was identified on the left buttock 16 days admission to the facility. According to the facility ' s policy, " Pressure Ulcer Prevention Protocol " Policy No. 104; issued 2011; stipulates: " Procedure: I. Risk Assessment: A risk assessment is done to determined the resident ' s risk for the development of pressure ulcers. The risk assessment scale that will be utilized is the Braden Scale ... II. Skin Assessment: 3. Inspect skin for signs of redness, change in temperature of skin ..., VI. Support Surfaces: 1. Use a higher-specification mattress rather than standard facility mattress for residents at risk. " According to the hospital discharge summary dated November 15, 2014 at 8:51 AM under the section " special instructions " included: " Left heel: Heel Eschar. Apply santyl to eschar on heels and redistribute the pressure of the affected area, R [Right] hand blisters/open areas/necrotic areas: Silvadene, dry dressing to R hand, esp [especially] black or necrotic areas BID [twice a day], R LE [Right Lower Extremity] wounds: Santyl to both RLE wounds with dry dressing (Allevyn) on top BID [twice a day] and Sacral Wound: NS [Normal Saline] WTD [Wet to Dry] dsg [dressing] changes to sacral wound BID. "	F 314		

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F 314	Continued From page 11 The physician " Admission Assessment Form " dated November 17, 2014 revealed that Resident #64 ' s chief complaint/reason for admission was skilled services for: " Multiple wounds, Decline in ADL [Activities of Daily Living]. Diagnoses included: " Multiple Decubitus Ulcers, A Fib [Atrial Fibrillation], CHF [Congestive Heart Failure], and Right Hand Wound. The " Admission Order Sheet and Physician Plan of Care " form revealed that Resident #64 was admitted to the facility on November 15, 2014 and diagnoses included: [Status Post] Acute Right Upper Forearm, Limb Ischemia, Status Post Embolectomy and Fascitomy, HTN [Hypertension], Status Post Hypomagnesmia, DM [Diabetes Mellitus], AKI [Acute Kidney Insufficiency], Stage 4 Sacral Wound. The " Admission Nursing Evaluation " form dated November 15, 2014 revealed the skin condition section identified that the resident was admitted with a " Stage IV Sacral Ulcer, Two (2) Stage 2 ulcers of the right lower extremity, and a left heel unstageable pressure ulcer. All the identified ulcers were depicted on an anatomical anterior and posterior body diagram. Resident #64 ' s " Braden Scale-For Predicting Pressure Sore Risk " was scored 8 on admission which indicates the resident was at " High Risk " for developing a pressure ulcer. According to the " Admissions MDS [Minimum Data Set] " with an ARD [Assessment Reference	F 314		

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F 314	Continued From page 12 Date] of November 21, 2014 indicated in Section G- Functional Status; resident was coded as total dependence with two+ (plus) persons physical assist for bed mobility. Section G0400- Functional Limitation in Range of Motion- Resident had upper extremity impairment on one side and impairment on both sides for lower extremities. Section H0300- Resident was always incontinent of bowel and urine. Section M: A Skin condition, resident was coded as being at risk of developing pressure ulcers. A review of Resident #64 ' s care plan initiated on November 15, 2014 included: " Alteration in skin integrity related to multiple hospitals acquired pressure ulcers. Approaches included: Conduct a systematic skin inspection weekly. Report any signs of further skin breakdown keep clean and dry as possible. Minimize skin exposure to moisture, obtain a dietary consult and use moisture barrier product to perineal area. " The " Admission Order Sheet and Physician Plan of Care " dated November 15, 2014 directed; " Pressure Ulcer Prevention: Moisture barrier cream to buttocks every shift and as needed after each incontinence episode, turn and position every 2 (two) hours, chart by shift; Magnesium Chloride, 64mg po [by mouth] daily for supplement According to the " Interim Order Form " dated November 15, 2014 at 6:00 PM directed the following:	F 314		

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F 314	Continued From page 13 " (1) Wet to dry dressing to Sacral Ulcer (2) Wet to dry dressing to (R) [right] forearm stitches (3) Wet to dry dressing to Stage II ulcers (R) right calves (4) Wet to dry dressing to left heel pressure ulcer (5) Wet to dry dressing to (R) right hand necrotic blisters (6) Continue wet to dry dressing daily until seen by the WOCN (Wound Ostomy Care Nurse) (7) Wound Care Consult. " A telephone " interim order " dated November 24, 2014 at 10:00 AM directed, " Please provide air mattress to relieve pressure to sacral area and prevent further skin or tissue breakdown. " A " Nutritional Assessment " dated November 22, 2015 revealed " Resident has multiple wounds, treatment started. Resident is being turned every two hours, resident is very heavy is unable to assist staff in turning self. Resident is assisted with all meals. PO [by mouth] intake about 50-75%. 30 ml [milliliters] Prosource TID [three times a day] for nutrition support and to promote wound healing. "	F 314		

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F 314	Continued From page 14 The resident was noted to be receiving Mag 64 po daily, Prosource Liquid -30 mls po three times a day and Vitamin D3 50,000 units ' po one day per week for 12 weeks. Further review of the Medication Administration Records (MAR) from November 15, 2014 to December 31, 2014 revealed that facility staff signed in the allotted spaces, indicating that moisture barrier cream treatments were administer to Resident #64 ' s buttocks as needed after each incontinence episode every shift as per the physician's order. According to a " Daily Skilled Nurse ' s Note " dated December 1, 2014 revealed: " Comments/Concerns Day Shift) revealed; " T&R [Turned and positioned] [every] 2 (two) hours. Treatment to wounds done as ordered .... Reddened area on left buttocks opened- 3 ½ x 1 ½ cm(centimeters). MD [Medical Doctor] and RP [Responsible Party] made aware. Comments/Concerns Evening Shift - Resident remains alert and responsive- Seen by wound team. New orders given ... " A review of the clinical record lacked evidence that any alteration in skin integrity to the left buttock was identified and documented prior to December 1, 2014. The Physician " Wound Notes " revealed the	F 314		

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following:

" December 1, 2014- 4PM- Patient seen today, was admitted to [facility named] with multiple pressure ulcers and open wounds.

1. Rt [Right] hand open wound (non -pressure) ...

2. Left heel eschar- Unstageable, Plan: Monitor, Float, Skin prep daily

3. Rt lower extremity ulcers pressure type- Stage 4 - " + " (positive) slough, " + " tendon, Plan: Xeroform
Dressing.

4. Sacral pressure ulcer- Stage 4- " + " slough, undermining, moderate serous drainage, No odor, Santyl on wound bed, Pack with AMD (Antimicrobal Dressing) gauze, Dermarite bordered, for plain x-ray - R/O [Rule out] Osteomyelitis.

5. Left buttock pressure ulcer- Stage 3- Full thickness, Xeroform dressing daily. (Newly identified wound).

Initial visit of the wound care team, identified a stage 3 pressure ulcer of the left buttock. There was no documented evidence in the clinical record that the resident was admitted with a left buttock pressure ulcer.

MD (Medical Doctor) Notes Continued:

December 10, 2014- 1 PM- Patient seen today has multiple wounds on different sites (hospital acquired)

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F 314	Continued From page 16 1. Rt. Hand open wounds (non-pressure) ... 2. Rt lower extremity pressure ulcers (two), Stage 4- Full thickness, " + " slough, [increased] pink tissue, moderate serous drainage. Plan: Xeroform dressing 3. Sacral pressure ulcer- Stage 4, " + " undermining, " + " slough, moderate serous drainage. Plan: Santyl and Solofite Phalt Packing. 4. Left heel eschar- Unstageable, Float, Skin prep daily December 17, 2014- 1PM- Patient seen today, has multiple wounds on different sites. 1. Rt hand necrotic wounds (non-pressure) 2. Sacral Pressure Ulcer- Stage 4, " + " slough- minimal, moderate serous drainage, [increased] Pink tissue, undermining, Plan: Santyl + Solosite Sheet packing, Plan: x-ray- [No] osteo. 3. Rt lower extremity pressure ulcers (two), Stage 4, Size [decreasing], healing slowly, [increased] Pink tissue - minimal slough, periwound skin intact. Plan: Xeroform dressing daily. 4. Left heel eschar- Unstageable, Plan: Float, Skin prep daily. December 31, 2014- 3PM- Patient seen today, has multiple wounds on different sites	F 314		

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F 314	Continued From page 17 1. Rt hand open wounds healing ... 2. Sacral pressure ulcer- Stage 4- [increased] pink tissue, minimal slough, periwound skin- open Wound (pressure type), moderate serous drainage, no odor, Plan- Estim, Santyl, Pack with Solosite Sheet 3. Rt Lower extremity pressure ulcers- Stage 4- slowly healing, [increased] pink tissue, minimal slough, moderate serous drainage. Plan: Xeroform dressing daily. Pressure relief. " The physician failed to consistently assess Resident #64 ' s wounds as evidenced by the following: December 1, 2014 - Five (5) wounds identified December 10, 2014 - Four (4) wounds identified; left buttock wound not identified December 17, 2014 - Four (4) wounds identified; left buttock wound not identified December 31, 2014- Three (3) wounds identified; left buttock wound and left heel not identified. The " Nurse ' s Admission Notes " dated November 15, 2014 at 8:15 PM, indicated that the resident had multiple wound sites, which included; " Left heel unstageable wound measuring 8.6 cm x 7cm and bilateral wound site on right lower leg. " The nurse ' s admission progress notes documentation did not include the " sacral ulcer-	F 314		

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F 314	Continued From page 18 Stage IV " that was identified on the admission assessment form. According to the facility's " Weekly Wound Healing Record " identified the following wound assessments: Date of Onset/Origin: November 15, 2014- Sacral Pressure Ulcer- (Hospital Acquired) - Stage 4- Size: 8.0 cm [centimeters] x 6.0 cm; depth- 2 cm; Exudate Type: Sero-sanguineous; Wound Bed- Granulation Tissue; Underming (cm)- 7 cm. Date of Onset/Origin: November 15, 2014- Right Lower Leg Pressure Ulcer (6A) - (Hospital Acquired) - Stage 3- 7.5cm x 4.5 cm; depth- 0.5 cm; Exudate Type: Sero-sanguineous, Wound Bed- Granulation Tissue, Slough. Date of Onset/Origin: November 15, 2014- Right Lower Leg Pressure Ulcer- (Hospital Acquired) - No stage identified- Size- 7.5 cm x 4.5 cm; 0 depth; Exudate Type: Serious, Wound Bed- Pink/Beefy Red. Date of Onset/Origin: November 15, 2014- Left heel Pressure Ulcer (Hospital Acquired) - Unstageable- Size: 8.6 cm x 7 cm; 0 depth; Exudate Type: None; Wound Bed- Black/Brown (Eschar) Date of Onset/Origin: December 1, 2014- Site/Location: Left Buttock Pressure Ulcer- Stage 3- 3 ½ x 1 ½ cm, 0 depth, Exudate Type: None, Wound Bed- Pink/Beefy Red A review of the clinical record for Resident #64 revealed an alteration in skin integrity to the left	F 314		

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F 314	Continued From page 19 buttock identified on December 1, 2014, sixteen (16) days after admission to the facility. No left buttock pressure ulcer was identified on admission. Facility staff failed to consistently assess Resident #64 ' s skin integrity to prevent a facility acquired Stage 3 pressure ulcer to the left buttock. Resident was identified as a high risk for the development of a pressure ulcer. A face-to-face interview was conducted with Employee #1 on May 6, 2015 at approximately 4:15 PM in regards to the left buttock pressure ulcer. Employee #1 stated that the resident was admitted to the facility from the hospital with the left buttock pressure ulcer. Further stated that the " smaller one [left buttock pressure ulcer] " was adjacent to the sacrum pressure ulcer at the margin. A face-to-face interview was conducted with Employee # 14 on May 6, 2015 at approximately 4:17 PM; he/she stated that when the left buttock pressure ulcer was assessed on December 1, 2014, there were two (2) different depths; therefore he/she had to document it as a left buttock ulcer and a sacrum ulcer. Further stated, that on December 10, 2014; the left buttock wound had probably healed or was getting better, that ' s why there was no documentation on the left buttock on December 10, 2014 and subsequent visits. The clinical record was reviewed on May 6, 2015.	F 314		
F 319	483.25(f)(1) TX/SVC FOR	F 319		

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F 319 SS=D	Continued From page 20 MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 40 sampled residents, it was determined that facility staff failed to provide alternative treatment interventions for Resident #236 with psychosocial adjustment difficulties. The findings include: A review of a psychiatrist ' s report dated September 5, 2014 revealed the following: Findings: " [Resident] presents with anger and frustration due to [his/her] general medical condition. " Declined to use mood stabilizer. Stated ' I just want to have freedom to go beyond the gates for fresh air and come back. I don ' t want to feel like I am locked up. ' " Under the area of diagnosis the resident was coded as 293.84 (Anxiety Disorder) and 293.83 (Mood Disorder). Under the area of recommendation it was stated, " No new psych (psychiatric) related medication recommended at this time as [he/she] is alert and oriented x3 (times three) and refused any mood stabilizer. "	F 319	**483.25(f)(1) TX/Soc for Mental Psychosocial difficulties** 1. A Review of the medical records and reports as it pertains to resident #236 was conducted. Alternative treatment and intervention were provided. Additional interactions have been added to resident's treatment plan. 2. A review of residents' at URCC who potentially Display mental or psychosocial adjustment difficulty was conducted. No other resident was impacted by this practice. 3. A meeting was held with nursing and social work staff. They were re-educated regarding residents with mental,and psychosocial difficulties. 4. Psychosocial needs and behavior documentation is a component of the social services department monitoring tool. This information is presented to the QA/QI committee.	7/9/15

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F 319	Continued From page 21 A review of the Social Service Progress notes revealed the following notes where the resident was verbally and physically abusive to other residents and staff: On March 7, 2015 the resident struck an employee on the left side of the face and shoulder with a metal cane. The resident was removed from the facility by Metropolitan Police and charged with assault. On March 14, 2015 the resident ' s roommate was removed from the room after he/she complained that the resident threatened to put a blade on [him/her]. On March 16, 2015 the facility staff held a meeting with the resident to discuss compatibility issues. On April 30, 2015 the resident was overheard threatening his/her roommate with bodily harm. Also on April 30, 2015 the resident was observed burning incense in his/her room. On April 30, 2015 at approximately 9:30AM the resident wheeled his/her wheel chair into the conference room while the nurse manager and the surveyor were having a conference used verbal expletives and threatened what he/she was going to do. A nurse ' s note dated May 1, 2015 at 10:15AM stated " [Resident] loud and angry. C/O [complained of] waffles not brought up with his/her breakfast tray. "	F 319		

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F 319	Continued From page 22 On April 20, 2015 the following care plans which identified behavior problems were updated: Problem: The " Exhibits risks for violence directed to others related to verbal and physical abuse, such as threatening, cursing & screaming. Actions Planned/Taken- to assist resident identify feelings/coping strategies by providing counseling as needed. Problem:Resists medications, injections and ADL assistance. Actions/Planned/Taken- to Assess expectations, cognitive status, attitude, motivation, lack of understanding, pain, intolerance/etc. Problem:Expresses persistent anger and possible frustration die to his/her general medical condition with self/others. Allow to have control over situation if possible. Actions/Planned/Taken- Allow resident to vent feelings and explore possible solutions with him/her. Encourage to become involved with physical activities Problem: Verbally and physically threatening to ...his/her roommate ... Actions/Planned/Taken-4/30/2015 Psychiatric consult. Moved to another room. Interviews: A face-to-face interview was conducted with the resident on April 30, 2015 at approximately 2:30PM. He/she stated that while he/she was being transported to an appointment the driver had called MPD (Metropolitan Police Department)	F 319		

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F 319	Continued From page 23 and tried to have him/her arrested. He/she added that he/she had not done anything to justify the call and felt that the facility was using the driver to assist in having him discharged. A face-to-face interview was also conducted with Employees #1 and 17 on May 6, 2015 at approximately 9:30AM. Employee #1 stated that the facility had transferred the resident to three different units and moved his/her roommate once in an effort to accommodate the resident ' s needs. Both employees acknowledged that the resident had demonstrated behavioral outbursts, anger and violence against residents and employees. The employees also acknowledged that the resident had been seen by a psychiatrist and diagnosed with Anger and Mood Disorders, had refused to take any medications to treat his/her conditions and was not enrolled in any form of Behavioral Therapy. There was no evidence that facility staff ensured when Resident #236 displayed mental and psychosocial behaviors that appropriate treatment and services were implemented in a timely manner. The record was reviewed on May 4, 2015.	F 319		
F 323 SS=D	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.	F 323		

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F 323	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to keep the resident free of accidents hazards as is possible as evidenced by using sharp scissors during a dressing change. Resident #180 The findings include: A right foot wound dressing change observation was conducted on May 4, 2015 at approximately 10:30 AM with Employee #12. He/she used sharp ended scissors to removed the old kerlix dressing from the resident ' s right foot. A face-to-face interview was conducted with Employee #1 in the presence of Employee #12 on May 4, 2015 at approximately 3:00 PM regarding the above wound treatment observation. Both acknowledged that bandaged scissors should have been used. The observation was made on May 4, 2015	F 323	**483.25 (h) Free of Accidents Hazards Supervision Devices** 1. Bandage Scissors were obtained for future dressing change for the resident #180. The resident was not impacted by this practice. 7/9/15 2. A review of all units was conducted. Bandage scissors were noted on each unit and in materials management no additional resident was impacted by this practice. 3. The nursing staff was re-educated regarding dressing change. Material management ordered additional bandage scissors to ensure supply readily available. Meeting was held with Materials Mgmt. regarding ensuring bandage scissors are available in central supply. 4. Treatment Administrator is monitored monthly. This information is presented in the QA/QI meeting.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 40 sampled residents, it was determined that the facility staff failed to accurately assess one (1) residents ' nutritional status after a significant weight gain. Resident #11. The findings include: The " Food and nutritional services policy # 18 section 9: Weight Gain or Loss ... stipulates ...Weight is a useful indicator of nutritional status, when evaluated within the context of the individual ' s personal history and overall condition... Residents are weighed every month ...The dietician /nutritionists evaluate weight loss/gain ...The dietician will evaluate the residents condition and make recommendations as needed. Recommendations may include the following: re-weigh the resident immediately for evaluation of true weigh, recommend weekly weights ... " A review of the clinical record revealed: Resident # 11 was hospitalized on August 17, 2014 and was readmitted to the facility on August 22, 2014. The post hospitalization diagnosis included: anemia, hypertension, cerebral palsy, dementia, depression, hydrocephalus congenital. His/her weight was recorded as 125.5lbs (pounds) on the " Admission Nursing Evaluation " form.	F 325	**483.05(i) Maintain Nutrition Status Unless unavoidable.** 1. A review of resident #11 was conducted. The resident was weighed by both nurse manger and ADON. The Dietician reassessed the resident and weekly weights x4 was initiated. The current weight was noted to be accurate. Unable to retrospectively correct. 2. A review of all residents weights was conducted. Residents with weight loss/gain were noted to be re-weighed and care planned. No other resident was impacted by this practice. 3. The nursing and dietary staff were re-educated regarding weights, re-weights and documentation. 4. Monitoring weights including weight loss/gain is a component of the weight committee. This information is presented to QA/QI committee.	7/9/15

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F 325	Continued From page 26 The review of the pre hospitalization weight was recorded on August 11, 2014 as 152 lbs. and the September 2014 monthly weight was recorded as 150 lbs. There was no evidence of a dietician's/nutritionist's assessment, and /or a reweight to determine and verify Resident ' s #11 ' s actual weight post hospitalization, when there was a 25 pound gain in weight from August 2014 to September 2014. The facility policy stipulates a dietician /nutritionists will evaluate weight loss/gain and make recommendations immediately to determine true weight. A face-to-face interview was conducted with Employees #5 and 6 on May 6, 2015 at 10:30 AM. When queried regarding the weight change, Employee #6 stated, "We are now aware of the August 22, 2014 weight change, and feel that it was the residents true baseline. Because given her/his physical appearance, all of his/her laboratory values have been normal we realized the weights were inaccurate and measures were initiated to verify. When queried regarding the lack of the dietician/ nutritionist assessment and intervention, Employee #5 stated " an assessment and a reweight should have been done and the dietician responsible for the resident at that time no longer works at the facility. " Employees # 5 and 6 acknowledged that the findings. The record was reviewed on May 6, 2015.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

(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 27 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 May 5, 2015 at approximately 10:30 AM, it was determined that the facility failed to prepare and store food under sanitary conditions as evidenced by two (2) of two 2) convection ovens that were soiled on the inside, two (2) of two (2) grease fryers that were soiled with fried food residue, a rusted fire sprinkler in refrigerator #3 a rusted fire sprinkler in refrigerator #1 and a fire sprinkler in the walk-in freezer that was covered with ice. The findings include: 1. Two (2) of two (2) convection ovens were soiled on the inside with burnt food spills. 2. Two (2) of two (2) grease fryers were soiled with fried food residue. 3. Fire sprinklers mounted at the ceiling of refrigerator #3 and refrigerator #1 were rusty. 4. The fire sprinkler mounted at the ceiling of the walk-in freezer was covered with ice. These observations were made in the presence of Employee #18 and/or Employee #8 who acknowledged the findings.	F 371	**483.35(i) Food Procedure, Store Prepare Serve Sanitary** 1. The convection ovens and grease fryers recently used were cleaned and sanitized immediately (at time of survey). The sprinkler company (ARK) was contacted immediately as it pertains to sprinklers identified. 2. A review of all other equipment in the kitchen was conducted. No other equipment was impacted by this practice. A review of the sprinklers was conducted and adjustments were made as indicated by the sprinkler company. 3. Cook Supervisors and Production staff have been re-educated on the correct cleaning procedures to follow to ensure quality sanitation standards are maintained. All cooks have been instructed to clean equipment immediately after usage. Meeting held with ARK (sprinkler company) regarding expectations when monitoring sprinkler. 4. Monthly Sanitation Audits are conducted by the Dietary Director or designee. This information is presented to the Quality Assurance Committee. Facilities Management monitors the sprinklers monthly. This information is presented to the QA committee.	7/9/15
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 28 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations made during Medication	F 431	**483.60 (b)(d)(e) Drug Records, Label/Store Drugs & Biologicals** 1. All medications unlabeled and undated were discarded immediately. All other multiple dose bottles of medication on unit identified were labels. 2. A review of all multi-dose bottles of medication was conducted. No other bottles were noted be opened and not labeled. 3. The licensed nursing staff were re-educated Regarding opening and dating multiple dose bottles when opened. 4. Monitoring the medication carts and storage of medication is a component of the QA/QI committee. This information is presented to the QA/QI Committee.	7/9/15

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F 431	Continued From page 29 Storage review on two (2) of five (5) units observed, it was determined that facility staff failed to write the opened dates on several multiple dose bottles of medications when they were opened. The following observations were made on Unit One (1) South at approximately 9:30AM on May 5, 2015: One 16oz bottle of Mineral Oil (app. 12oz left) Expiration Date 01/2016 One 30oz bottle Liquid Prosource (app. 6oz left) Expiration Date 01/2016. The observations were made in the presence of Employee #19. He/she acknowledged the finding. The following observations were made on Unit One (1) North: One 32oz Container High Fiber (app. 14oz left) Expiration date 01/2017 One 13oz container Reguloid Vegetable Laxative Powder (app 8oz left) Exp. Date 09/2017 One 8oz bottle Tussin (app. 4oz left) Exp. date 03/2016 One 16oz Bottle Lactulose syrup (app. 120z left) Exp. date 04/2016 One 16oz bottle of Ferrous Sulfate (app 8oz left) Exp. date 03/2016 One 16oz bottle Valporic Acid (app. 8oz left) Exp. date 09/2016 One 16oz bottle KCL (Potassium Chloride) Solution (app 6oz left) Exp. date 07/2016 The observations were made in the presence of Employee #10. The employee acknowledged the finding.	F 431		

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**483.65 Infection Control, Prevent Spread, Linens** **1.** 1.The nursing staff member washed their hands; however did not have on gloves, when buttering the bread. She was re-educated regarding this immediately. 2. A review of other staff preparing meals for residents was conducted. No other resident was impacted by this practice. 3. The nursing staff was re-educated regarding preparation of meals. 4. Monitoring the meal service is a component of the resident advocacy program. This information is presented in the QA/QI committee. 2. 1. Observation of nursing staff providing treatment to resident#180 was conducted. Unable to retrospectively correct during survey, however process corrected immediately for future treatment. 2. A review of nursing staff conducting treatment was conducted. No other resident was impacted by this practice. 3. The nursing staff were re-educated regarding treatment administration particularly as it pertains to infection control. 4. Monitoring treatment administration and infection control is a component of the QA/QI program and is presented in the QA/QI committee.	7/9/15 7/9/15

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F 441	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for two (2) of 40 sampled residents, it was determined that facility staff failed to decrease possible cross contamination of food as evidenced by using bare hands to serve one (1) resident his/her food; decrease the spread of infection as evidenced by not placing a drape/barrier under the residents foot during wound treatment. Residents' #5 and #180 The findings include: 1. Facility staff failed to decrease possible cross contamination of food as evidenced by using bare hands to serve Resident # 5 his/her food. A dining observation was conducted on April 28, 2015 at approximately 12:30 PM Employee #15 used bare hands to prepare bread with butter for two (2) residents without sanitizing hands or using eating utensils. A face-to-face interview was conducted with on May 5, 2015 with Employee #15 at approximately 1:30 PM. He/she stated " I did not have gloves, gloves are now on the cart. I did not know if I can use gloves or not. " Facility staff failed to decrease the spread of infection as evidenced by using his/her bare hands to prepare a resident food. 2. Facility staff failed to decrease the spread of infection as evidenced by not placing a drape/barrier under Resident #180's foot during wound treatment.	F 441		

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F 441	Continued From page 32 A wound treatment observation was conducted on May 4, 2015 at approximately 10:30 AM with Employee #12. The following occurred: Employee #12 removed the kerlix dressing from the left foot of the resident. A 2x2 gauze was adhered to the wound on the left lateral foot area. The employee poured normal saline solution to moisten the dressing in order to remove it from the wound. Employee #12 failed to place a barrier underneath the left foot allowing the normal saline solution to drop on the resident ' s right foot, which was dressed with a white sock and residents pants. A face-to-face interview was conducted on May 4, 2015 with Employee's #1 and #12 at approximately 1:00 PM. After review of the above both acknowledged the findings. Facility staff failed to decrease the spread of infection secondary to not placing a drape/barrier under one (1) foot during wound treatment.	F 441		
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;	F 514		

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F 514	Continued From page 33 and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; and readily accessible; as evidenced by failure to ensure that an Initial Nursing Assessment for one (1) hospice resident was a part of the residents active clinical record. Residents' #180 The findings include: 1. Facility staff failed to ensure that an initial nursing assessment for Resident #180 was a part of the resident's active clinical record. A review of the Interim Order Form dated March 4, 2015 directed ... " Hospice consult with [Hospice facility Name] indication: End Stage Dementia; Interim Order Form dated March 9, 2015 directed ...Please admit to hospice with Dx [Diagnosis] Dementia " Further review of the active clinical record for Resident #180 lacked evidence of an Initial Nursing Assessment. At this time Employee #11 was queried as to the whereabouts of the assessment. Employee #11 retrieved the Initial Nursing Assessment via fax from the Hospice Agency and placed them in the active clinical record. The record was reviewed on May 4, 2015.	F 514	**483.75 (1) Resident Records- Complete Accurate/ Accessible** 1. The initial assessment by nursing was completed timely. The hospice initial assessment was completed but not in the record at time of survey. Survey agency was provided a copy of the assessment for resident #180. 2. A review of all hospice residents in the center was conducted. No other resident was impacted by this practice. 3.The hospice agency was contacted and advised of the importance of ensuring all documentation were placed in the record at time of completion. Nursing staff were re-educated regarding documents hospice should ensure are in medical record. 4. Monitoring documentation is a component of the QA program. Monitoring documentation as it pertains to hospice has been added to the QA program and is presented to the QA/QI committee.	7/9/15

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