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L 000	Initial Comments	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview, facility staff failed to develop and implement a comprehensive person-centered care plan with goals and approaches to address the monitoring and side effects of Trazadone (antidepressant and sedative) for one (1) of 43 sampled residents, Resident #178.	L 051	Unique Rehabilitation and Health Center make 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 POC is prepared and/or executed solely because it is required by Federal and State Laws.	

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L 051	Continued From page 1 Findings included ... Resident #178 was admitted to the facility on 9/17/2019, with diagnoses that included Cancer, Orthostatic Hypotension, Benign Prostatic Hyperplasia (BPH), Hyperlipidemia, Retention of Urine and Depression. Review of the Nurse Practitioner's progress note dated 6/29/2020, at 13:36 (1:36 PM), showed, "Psych Consult: Insomnia... Diagnosis: Axis1: Adjustment d/o (disorder) with depressed mood, Insomnia. Plan: Start Trazodone 50mg (milligrams) po (by mouth) qhs (every night). Monitor Mood and Behavior". A review of the physician's order dated 6/29/2020, showed active diagnosis of "Major Depressive Disorder, Recurrent Unspecified"; an order for, "[Trazadone] HCl (Hydrochloride) tablet 50 MG (milligram) give 50 mg by mouth in the evening for Depression/insomnia Monitor for SI (suicidal ideation)". Further review showed a black box pharmacy warning which stipulated, "Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors". Facility staff failed to develop a person centered care plan with goals and approaches to address the new diagnosis (depression) and monitoring of side effects such as suicidal ideation, lack of sleeping, worsening depression and for adverse interactions such as, dizziness, nervousness or anxiety for Resident # 178 who was prescribed a new medication (Trazadone).	L 051	**1. Corrective action for the Resident Affected:** Resident #178 was re-assessed on 10/09/2020. Resident #178 comprehensive care plan was revised to include goal and approaches addressing diagnosis of depression including side effects monitoring. Resident #178 did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents have the potential to be Affected. Nurse managers completed review of residents' with diagnosis of depression medical records to ensure corresponding care plan reflecting goals, approaches and monitoring of side effects. No other residents were affected by this deficient practice.	12/11/20

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L 051	Continued From page 2 During a face-to-face interview on 10/8/2020, at approximately 1:25 PM, Employee #6, stated, "I update the care plan as needed and during IDT (interdisciplinary team) meetings. Any new diagnosis, medications-I will make the update." Employee #6 (unit manager) acknowledged the findings. B. Based on record reviews and staff interviews for five (5) of 43 sampled residents, facility staff failed to update the care plan with goals and approaches to address one (1) resident who had an accident with injury, failed to address the removal of two (2) dialysis residents access site dressings post dialysis, failed to address one (1) resident use of the wound vacuum-assisted closure (VAC), and failed to address one (1) resident refusal to have his weight obtained. Residents' #11, #61, #114, #149 and #158. Findings included... 1.Facility staff failed to update the care plan to reflect Resident #11's accident with injury. Resident #11 was admitted to the facility on November 4, 2016, with diagnoses that included Osteoporosis, Parkinson Disease, Hypertension, Encephalopathy, Dysphagia, Major Depressive Disorder, Bipolar Disorder, and Schizophrenia. A review of the progress note dated May 5, 2020, at 5:53PM showed, "At approximately 4:55PM writer was called to report to 3 south to assess this resident. Resident was noted to have a minor cut at the bridge of his nose and 2 minor crates	L 051	**3. Measures to prevent recurrence:** Staff Development Director will in-service interdisciplinary team members to ensure residents' care plans are person-centered with goals and interventions addressing resident's diagnosis. Nurse managers will conduct weekly audit x4, monthly x 3. Audit findings will be submitted to the Director of Nursing for review. **4. Monitoring to prevent recurrence:** Director of Nursing / Designee will review reports during weekly risk meeting to ensure compliance greater or equal to 95% has been achieved. Reports of finding will be submitted to Quality Assurance Committee monthly x 3.	12/11/20

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L 051	Continued From page 3 [scrapes] on the fore head. ...staff assisting resident said that he was assisting resident to the chair and while he was still holding him, he hit is head at the counter in the nurses station. Resident did not fall, the staff held him when this incident occured." A review on October 7, 2020 showed that facility staff failed to update Resident #11's care plan to reflect the accident with injury on May 5, 2020. During a face-to-face interview on October 9, 2020, at approximately 1:15 PM, Employee #2 (DON)acknowledged the findings. 2. Facility staff failed to update Resident #61's care plan to reflect the removal of the resident's access site dressing post dialysis. A review of the Policy and Procedure title Hemodialysis Revised 07/02/2020 showed "5. The facility licensed nurses will be responsible for removing the protective dressing of graft/fistula site after 4 hours of resident return from dialysis." Resident #61 was admitted to the facility on July 22, 2016, with diagnoses to include End-stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, and Anemia A review of a Physician's order dated September 29, 2020 showed "Resident is Dialysis days are Monday, Wednesday and Friday at 3pm at [dialysis name] Dialysis Center ... 3 times a week every Mon, Wed, Sat [Friday] for dialysis." A review of the Progress note dated September 1, 2020 through October 9, 2020 showed that resident #61 access site dressing were removed	L 051	**1. Corrective action for the residents affected:** Resident #11 was reassessed on 10/10/2020. Care plan was updated to 10/10/2020. Resident #11 did not suffer any negative outcome. Residents #61 and #158 were reassessed on 10/10/2020. Care plans of residents #61 and #158 were revised and updated on 10/10/2020. Residents #61 and #158 did not suffer any negative outcome. Resident #114 was reassessed on 10/10/2020. Care plan was revised and updated on 10/10/2020. Resident #114 did not suffer any negative Outcome. Resident #149 was reassessed on 10/10/2020. Care plan was revised and updated on 10/10/2020. Resident #149 did not suffer any negative Outcome.	12/11/20

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L 051	Continued From page 4 on the following dates mentioned below: 9/2/20 8:28 AM "RUE (right upper extremity) AV (arteriovenous) graft dressing remain intact, 10:50 PM Dressing intact - removed" 9/6/20 7:37AM RUE AV graft dressing remain intact, 3:42 PM Dressing off" 9/30/20 10:43 PM "Compression dressing to right upper arm AV graft, removed" 10/1/20 2:48 PM "Compression dressing to right upper arm AV graft, removed" 10/6/20 10:33 AM "Compression dressing to right upper arm AV graft, removed" 10/7/20 9:57 PM "Compression dressing to right upper arm AV graft, removed" A review of the care plan on October 9, 2020 showed that facility staff did not update Resident #61's care plan to reflect the removal of the resident's access site dressing post dialysis. A face-to-face interview conducted with Employee#2 (DON) on October 9, 2020 at approximately 1:15 PM. The employee acknowledged the findings. 3. The facility staff failed to update Resident #114's care plan with person centered goals and approaches to address use of the wound vacuum-assisted closure (VAC) (a method of decreasing air pressure around a wound to assist the healing). Resident #114 was admitted to the facility on November 15, 2019 with diagnoses that included: Anemia, Hypertension (HTN), Diabetes Mellitus, Thyroid Disorder, Osteoporosis, Encephalopathy and Sacral Pressure Ulcer.	L 051	**2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Nurse Managers completed audits of residents medical records to ensure that care plan of residents with documented incident / accident reflects and address accurately the documented incident. No other residents were identified. Nurse managers completed audits of care plans of residents receiving dialysis to ensure that care plans address removal of protective dressing of graft/fistula site post dialysis as ordered by physician. No other residents were identified. Nurse managers completed audit on medical record of residents with the use of wound vacuum assisted closure to ensure that care plans reflect person-centered goals and approaches including instructions specific to physician order for use of the wound vac. No other residents were identified. Nurse managers completed audit of residents' medical records to ensure care plans of residents refusing care are updated to reflect and address approaches to obtain weight. No other residents were identified.	12/11/20

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L 051	Continued From page 5 The physician's order dated July 27, 2020, directed, "Sacaralgluteal Wound - Cleanse with daikins solution and apply Negative Pressure Wound Treatment (Wound vac for 72hours) on Mondays." Review of the Resident's focus care plan last reviewed by facility's interdisciplinary team (IDT) on September 24, 2020, showed, "Sacral pressure ulcer stage 4 ...is on a wound vac ... Care plan goals reviewed and updated. Current POC (plan of care) continues". The interventions listed on the care plan were not person-centered to include instructions specific to the physician's order for use of the wound vac as referenced above. During a face-to-face meeting on October 9, 2020, at 10:47 AM the Employee #4, unit manager acknowledged the findings. 4. Facility staff failed to revise the care plan for Resident #149 with person centered goals and approaches to address his refusal to have his weight obtained. Resident #149 was admitted to the facility on February 8, 2018, with diagnoses that includes: Cirrhosis, End Stage Renal Disease (ESRD), Dementia, Seizure Disorder, Asthma and Respiratory Failure. On the Quarterly Minimum Data Set (MDS) dated August 17, 2020, the residents Brief Interview of Mental Status (BIMS) score was "7" indicating that he has severe cognitive impairment. Review of this weight record on October 2, 2020, revealed the following:	L 051	**3. Measures to prevent Reoccurrence:** Staff Development Director will provide in-service to interdisciplinary team members on the importance of updating care plans and consistent documentation reflecting person-centered goals and approaches to address incident, refusal of care, post dialysis fistula/graft removal, and use of wound vac. Nurse Managers will conduct weekly audit x 4 weeks, and monthly x 3. Audit findings will be submitted to Director of Nursing for review.	12/11/20

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L 051	Continued From page 6 2/7/2020 178.4 Lbs [pounds] 1/15/2020 176.1 Lbs 12/9/2019 175.7 Lbs 11/5/2019 173.2 Lbs 10/11/2019 176.4 Lbs 9/13/2019 174.2 Lbs Review of the progress notes showed the following: "8/18/2020 at 16:48 [4:48 PM] Quarterly Review - Resident's last weight recorded 2/7/2020- 178.4[pounds]. He has not allowed the staff or this writer to weigh him. Therefore, weight status is undetermined for 30, 90 and 180 days. Resident was again approached today for consent to be weighed, but stated 'that's a stupid question'. He receives Regular, regular Texture diet and consumes 50 - 100% of meals per nursing. No pressure wounds cited at this time." Review of the care plan revised on August 8, 2020, showed: "Potential/Alteration in Nutritional status r/t (related to) h/o (history of) Cirrhosis, Anemia, Hx (history). Malnutrition; Dementia; Meds" 6/1/2020-Resident declines weight monitoring since march 2020. 8/18/2020- Resident continues to decline weight monitoring despite education. [Resident #149] is at risk for a behavior problem (agitation) r/t history of agitation and diagnosis of dementia with behavioral disturbance". The interventions listed on the care plan were not person-centered to include approaches to obtain the residents weight. During a face-to-face interview October 7, 2020, at 11:56 AM, Employee #4 acknowledged the	L 051	**4. Monitoring Corrective Action:** Director of Nursing/Designee will review report during weekly risk meeting to ensure greater than or equal to 95% compliance and forward monthly x 3 to Quality Assurance Committee.	12/11/20

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L 051	Continued From page 7 findings. 5. Facility staff failed to update Resident #158's care plan to reflect the removal of the resident's access site dressing post dialysis. A review of the Policy and Procedure title: Hemodialysis, Revised 07/02/2020 showed "5. The facility licensed nurses will be responsible for removing the protective dressing of graft/fistula site after 4 hours of resident return from dialysis." Resident #158 was admitted to the facility on November 21, 2014, with diagnoses to include Anemia, Hypertension End stage Renal Disease, Dependence on Renal Dialysis, Diabetes Mellitus. A review of a Physician's order dated September 17, 2020 showed "Resident is on Dialysis, Hemodialysis on Tues [Tuesday], Thurs [Thursday], and Sat [Saturday] at [Hospital name] outpatient every day shift [Tuesday], [Thursday], [Saturday] for Dialysis." A review of the Progress note dated September 1, 2020 through October 9, 2020, showed the dressings to the resident's access site were intact on the following dates and time: "9/24/20 9:56PM Left AV [Arteriovenus] graft site dressing intact, 10/4/20 4:28 AM Left AV graft site dressing intact". However, there was no documented record in the progress note to show that the resident's dressing was removed. A review of care plan on October 9, 2020, showed that facility staff did not update Resident #158's care plan to reflect the removal of the resident's access site dressing post dialysis.	L 051		

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L 051	Continued From page 8 During a face-to-face interview on October 9, 2020, at approximately 1:15 PM Employee #2 (DON) acknowledged the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating;	L 052		

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L 052	Continued From page 9 (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations, record review and staff interview, for one (1) of 43 sampled residents, facility staff failed to treat residents with dignity and respect during dining observations for one (1) resident. Resident #1 Findings included... Facility staff failed to treat Resident #1 with dignity and respect during two (2) dining observations. Resident #1 was admitted to the facility on 5/7/2004, with diagnoses that included Hypertension (HTN), Benign Prostatic Hyperplasia (BPH), Diabetes Mellitus (DM), Hyperlipidemia and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated 5/4/2020, Section G (Functional Status) indicated Resident #1 required one-person physical assist support while eating.	L 052	**1. Corrective Action for the resident Affected:** Resident #1 was re-assessed on 10/08/2020. Resident #1 suffered no negative outcome from the deficient practice. Employees #6, #13, & #21 were provided re- education on how to ensure dignity and respect for residents during meal time. Employees were in-serviced on the importance of sitting at a face level while assisting residents with feeding. **2. Identification of Others with Potential to be Affected:** All residents residing in the facility have potential to be affected. Nurse managers conducted facility wide audit to ensure that residents that require feeding assistance are treated with dignity and respect during meal time. Identified issues were immediately addressed.	12/11/20

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L 052	Continued From page 10 During a tour of unit 2 South on 10/5/2020, at 1:32 PM, Resident #1 was observed seated in bed (a semi-sitting position of 45-60 degrees) being fed by Employee # 6 (unit manager) who was standing. At 1:45 PM, Employee #13 (certified nursing aide), who had taken over for Employee #6, was also observed standing while feeding Resident #1. During a second tour of unit 2 south on 10/8/2020, at approximately 1:30 PM, Employee #21 (certified nursing aide) was also observed standing up while feeding Resident #1. Facility staff failed to provide Resident #1 with dignity and respect during two (2) dining observations. During a face-to-face interview conducted on 10/8/2020, at 1:38 PM, Employee #6 stated, "Staff are educated on how to provide dignity when feeding. If anyone is not doing it properly then they must be new." During the interview, Employee #6 acknowledged the findings. B. Based on observation, record review and staff interview, facility staff failed to secure the indwelling catheter tubing and failed to maintain urinary catheter drainage systems below the level of the bladder for two (2) of 43 sampled residents. Residents' #35 and Resident #178. Findings included... A review of the facility's policy entitled, "Urinary Catheterization/Foley Care" dated 7/15/2020,	L 052	**3. Measures to prevent recurrence:** Staff Development Director will educate nursing staff on providing assistance to residents that require one person physical assist support while eating. Education will emphasize on the importance of sitting at face level with residents while providing feeding assistance to ensure residents are assisted with dignity and respect. Assistant Director of Nursing / Designee will conduct rounds during meal time to ensure residents that require physical assistance while eating receive feeding assistance with respect and dignity. **4. Monitoring Corrective Action:** Director of Nursing/Designee will review reports and findings weekly during risk meeting and forwarded to the Quality Assurance Committee monthly x 3.	12/11/20

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L 052	Continued From page 11 showed, "...Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma... Drainage bags should always be placed below the level of the patient's bladder to facilitate drainage [allows the urine to drain by gravity and prevents it from flowing back into the bladder] and prevent stasis of urine." According to Cleveland Clinic "...Always keep your urine bag below your bladder, which is at the level of your waist. This will prevent urine from flowing back into your bladder from the tubing and urine bag, which could cause an infection." https://my.clevelandclinic.org/health/articles/14832-urine-drainage-bag-and-leg-bag-care 1. Resident #35 was admitted to the facility on 12/20/2019, with diagnoses that included Neuralgia, BPH (Benign Prostatic Hyperplasia), Muscle weakness and Neuritis. Review of the Quarterly Minimum Data Set (MDS) dated 6/27/2020, Section G (functional status), showed Resident #35 coded as "extensive assistance" for self-performance, indicating that resident required one-person physical assist for dressing and toilet use. Under Section H (Bladder and Bowel), the resident was coded as having an indwelling catheter. During a tour of unit 2 south on 10/8/2020, at approximately 1:30 PM, Resident #35 was observed with urinary catheter tubing visible outside of pants, tubing coming from waist band (above the bladder) with bedside drainage bag hooked to wheelchair.	L 052	**1. Corrective action for the resident Affected:** Residents #35 and #178 were re-assessed on 10/08/2020. Urinary drainage bags were replaced with leg bags and secured with leg straps on both residents to prevent trauma and ensure catheter tubing placed below the bladder to prevent back flow and infection. Residents #35 and #178 did not suffer any negative outcome. Employees #14 and #6 were both provided with counselling by the nurse manager on 10/08/2020 on the importance of securing urinary drainage catheter, placing urinary bag below bladder to prevent backflow, and use of leg bag to ensure residents' privacy and dignity.	12/11/20

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L 052	Continued From page 12 Review of the physician's order dated 1/13/2020, at 23:00 [11:00 PM] showed, "Check catheter and tubing for kink every shift ... for Urinary retention". Further review of the care plan dated 7/27/2020, showed, " ...Catheter: Position catheter bag and tubing below the level of the bladder and away from entrance room door .... Check tubing for kinks each shift ..." During a face-to-face interview conducted on 10/8/2020, at 1:38 PM, Employee #14 (certified nursing assistant, CNA), stated, "I got [Resident #35] dressed this morning. Yes, I know to secure the tubing. I am going to get a leg strap [provides privacy, prevents tubing from catching or pulling from regular movements] once I finish feeding this resident." Employee #14 (CNA), acknowledged catheter was inappropriately placed. Facility staff failed to keep the urinary catheter tubing secured on the resident to prevent urethral trauma and failed to ensure the catheter tubing was placed below the bladder to prevent the back flow of urine into the bladder of Resident #35. During a face-to-face interview conducted on 10/8/2020, at 1:45 PM, Employee #6 (unit manager), stated, "Staff receive in-service on catheter care and dignity. I already talked to the CNA (Employee #14) this morning about securing the catheter and the leg strap, we are getting the leg strap now." Employee #6 (unit manager), acknowledged the findings. 2. Resident #178 was admitted to the facility on 9/17/2019, with diagnoses that included Cancer,	L 052	**2. Identification of others with potential To be affected:** Facility residents with the use of urinary Catheter have potential to be affected. Nurse managers completed audit of residents with the use of urinary catheter on 10/08/2020 to ensure that identified resident have catheter secured to the leg with strap to prevent trauma and back flow and use of a leg bag for privacy and dignity. No other residents were identified.	12/11/20

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L 052	Continued From page 13 Orthostatic Hypotension, BPH, Hyperlipidemia, Retention of Urine and Depression. Review of the MDS dated 8/26/2020, showed in Section G (functional status), Resident #178 is coded as "extensive assistance" for self-performance, indicating that resident required one-person physical assist for dressing and toilet use. Under Section H (Bladder and Bowel), the resident was coded as having an indwelling catheter. During a tour of unit 2 south on 10/6/2020, at 11:04 AM, Resident #178 was observed ambulating on the unit with urinary catheter tubing visible outside of pants, tubing coming from waist band (above the bladder) with bedside drainage bag hooked to walker. Review of the physician's order dated 1/13/2020, at 23:00 (11:00 PM) showed, "Check catheter and tubing for kink every shift ... for Urinary retention". Facility staff failed to keep the urinary catheter tubing secured on the resident to prevent urethral trauma and failed to ensure the catheter tubing was placed below the bladder to prevent the back flow of urine into the bladder for Resident #178. During a face-to-face interview conducted on 10/6/2020, at approximately 11:15 AM, Employee #6 (unit manager), stated, "I am sending the nurse down now to get a leg strap and drainage bag." Employee #6, acknowledged the findings.	L 052	3. **Measures to prevent recurrence:** Staff Development Director will provide education to nursing staff on urinary catheter and care. Training will focus on the importance of placing drainage bags below the level of residents'' bladder to facilitate drainage and prevent back flow or infection. Staff Development Director will also train on the importance of securing the tubing catheter to the leg to prevent trauma with the use of leg bag to ensure residents dignity and privacy. Assistant Director of Nursing/Designee will conduct daily round on residents with the urinary catheter to ensure that catheters are secured, urinary bags are placed below the bladder, and leg bags are being used to ensure residents' privacy and dignity when leaving the unit. Findings will be submitted to the Director Of Nursing weekly x 4 and monthly x 3 for review. **4. Monitoring corrective action:** The Director of Nursing/Designee will present report weekly during risk management meeting and forward to Quality Assurance Committee monthly x 3.	12/11/20
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free	L 099		

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L 099	Continued From page 14 from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by breakfast food items such as scrambled eggs and ground turkey that were tested below 135 degrees Fahrenheit (F), and inconsistent food temperatures documentation during the months of July, August, and September 2020. Findings included ... 1. Facility failed to maintain breakfast food temperatures that were safe and appetizing to Resident #51. During a face-to-face interview with Resident # 51 on 10/01/20, at 11:32 AM, he stated, "My food in the morning is cold." On October 7, 2020, at 8:57 AM a test tray containing breakfast foods was measured to determine the food temperatures. The food temperatures were as follows: Ground turkey from the regular diet test tray tested at 119.2 degrees F, and scrambled eggs tested at 123.3 degrees F. Breakfast food temperatures were inadequate and failed to test above 135 degrees Fahrenheit (F). During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	L 099	**1. Corrective action for the Resident affected.** Resident #51 is stable and resides in the facility. Resident #51 has been encouraged to report food temperature issue for immediate follow up. Resident #51 did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Interdisciplinary team members completed residents' interview on all units to identify complain of disatisfaction with meal temperature and presentation. No other residents were identified As being affected.	12/11/20

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L 099	Continued From page 15 2. Dietary staff failed to document tray line food temperatures consistently during the months of July, August, and September 2020. Breakfast, lunch, and/or dinner tray line food temperatures were not documented as follows: Four (4) out of 31 days in July 2020 Eight (8) out of 31 days in August 2020 Fifteen out of 30 days in September 2020. During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	L 099	**3. Measures to prevent recurrence:** Director of Food Services will provide in-service for dietary staff on the importance of providing meals at temperatures that are safe and apetizing at minimum of 135 degrees (F) on delivery. Training will emphasize on the importance of consistent documentation of tray line food temperature for all meals. Dietary Supervisor will conduct test trays two days every week to ensure appropriate food temperatures when delivered to the unit. Meal temperature log will be audited daily by Dietary Supervisor to ensure consistent and accurate meal temperature documentation. Identified issues will be reported to the Director of Food Services.	12/11/20
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate	L 128	**4. Monitoring corrective action:** Director of Food Services / Designee will submit report including issues identified and addressed to Quality Assurance Committee monthly x 3.	

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L 128	Continued From page 16 reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 43 sampled residents, facility staff failed to minimize potential adverse consequences related to medication therapy for one (1) resident on two occasions and failed to maintain the pharmacy drug regimen review on the active record for one (1) resident. Residents' # 50 and #172. Findings included.... 1A. Facility staff failed to minimize potential adverse consequences related to medication therapy for Resident #50 who had an elevated thyroid stimulating hormone (TSH) level. Resident #50 was admitted to the facility on 9/26/2019, with diagnoses that included Anemia, Heart Failure, Hypertension (HTN), Renal Insufficiency, Schizophrenia, Hypothyroidism and Depression. Laboratory test results showed the following: "Date of test: 02/03/20 Type of test: TSH 16.321(H) [high] (normal range 0.350-4.940)." "Date of test: 02/04/20 Type of test: TSH 15.512(H) (normal range: 0.350-4.940) ulU [International Units]/mL [milliliters]." A review of the physician's order dated 2/26/2020, at 5:21 [AM] showed, "Levothyroxine Sodium	L 128	**1. Corrective action for the residents affected:** Resident #50 was re-assessed. TSH level ordered and to be repeated every 3 months. EKG ordered to be done for baseline and every 6 months. Result of the TSH level and EKG have been reviewed by physician to be within normal limit with no new order. Resident #50 did not suffer any negative outcome. Resident #172 pharmacy drug regimen review was completed by pharmacist consultant for November without new recommendations. All pharmacy drug regimen monthly review have been made available in resident medical record. Resident #172 did not suffer any negative outcome.	12/11/20

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L 128	Continued From page 17 Tablet 200 MCG (micrograms) Give 1 tablet by mouth in the morning for [Hypothyroidism]". A review of the document entitled, "Consultant Pharmacist's Medication Review" dated 3/1/2020 "For Recommendations Created Between 2/1/2020 And 2/29/2020" showed on page 6, " ... [Resident #50] is ordered Levoxyl 150 mcg daily for hypothyroidism. His recent TSH was still elevated at 15.15. Please consider increasing the Levoxyl dose to 175 mcg daily at 0600 (6:00 AM) for [Hypothyroidism] and a follow-up TSH in 6-8 weeks." In addition, subsequent review showed Consultant #1 (pharmacist) documented on the "Pharmacy Drug Regimen Review" on dates 6/9/2020, 7/11/2020, 8/7/7/2020, and 9/8/2020, "No clinically significant medication issues were identified during the drug regimen review." There was no evidence that Consultant #1 followed up on the irregularity that was identified on 3/1/2020. During a telephone interview conducted on 10/6/2020, at 12:12 PM, Consultant #1 stated, "Resident's TSH levels have been hard to regulate. I asked for follow-up labs 6-8 weeks in February." During a telephone interview conducted on 10/6/2020, at 1:19 PM, Employee #16 (medical doctor), stated, "We should have repeated another TSH level. The patient has been difficult to regulate due to underlying disease. Will order follow-up lab." Facility staff failed to act on elevated TSH level since February 2020 for Resident #50.	L 128	**2. Identification of others with potential to be affected:** All residents residing in the facility have potential to be affected. Nurse managers conducted facility wide audit on residents receiving therapeutic regimen requiring Thyroid Stimulating Hormone (TSH) level monitoring with 90 day look back to ensure that abnormal TSH results are addressed by physicians. No other residents were identified as being affected. Nurse managers audited residents' medical records for pharmacy warning label to ensure that they are being addressed by physicians, and residents receiving anti-psychotic with cardiac related diagnosis have EKG baseline and routine monitoring. No other residents were identified as being affected. Nurse managers completed audit of Residents' medical records to ensure residents monthly pharmacy drug regimen is completed and available in residents active medical records. No other residents were identified as being affected.	12/11/20

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L 128	Continued From page 18 1B. Facility staff also failed to minimize potential adverse consequences related to medication therapy for Resident #50 who receives Haloperidol and Seroquel (both antipsychotic medications used to treat Schizophrenia). Review of the physician's order for Resident #50 showed, "Haloperidol Tablet 5 MG ... Give 1 tablet by mouth at bedtime for Schizoaffective disorder... Start date 7/26/2020". "Seroquel Tablet 50 mg ... Give 1 tablet by mouth at bedtime for Schizoaffective disorder.... Start date 7/26/2020". The pharmacy warning label proceeding the order for Haloperidol indicated, "... increase QT interval (the time from the start of the Q wave to the end of the T wave) with Seroquel". Review of the medical record lacked evidence of monitoring of the resident's QT interval from 7/26/2020. During a telephone interview conducted on 10/6/2020, at 12:12 PM, Consultant #1 stated, "A baseline EKG (electrocardiogram) not required based on my clinical pharmacy resource. Resident is not at risk; he doesn't have history of heart issues. I did not make the recommendation." However, review of the diagnoses listed in the MDS dated 7/1/2020, indicated resident does have history of heart disease. During a telephone interview conducted on 10/6/2020, at 1:19 PM, Employee #16, stated, "EKG should have been done. Will follow-up and	L 128	**3. Measures to prevent recurrence:** Medical director will provide education to physicians and facility pharmacy consultant on timely, consistent, and appropriate follow up with resident medical records, including abnormal lab value results and completion of monthly pharmacy drug regimen for residents to include evidence of completion by making recommendations available in resident active medical records. Nurse managers will audit residents' medical records daily during clinical round to ensure that; abnormal lab results have been addressed by physicians, pharmacy warning labels are reviewed, monthly pharmacy drug regimen for residents are completed and available in residents' active medical records. Findings will be submitted to the Director of Nursing weekly x 4 and monthly x 3.	12/11/20

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L 128	Continued From page 19 get one." Facility staff failed to obtain a baseline electrocardiogram (EKG) for Resident #50 who was prescribed medications that have increase risk for QT interval prolongation. During telephone interviews conducted on 10/16/2020, both Consultant #1 and Employee #16, acknowledged the findings. 2. Facility staff failed to maintain the Pharmacy drug regimen review on the active record for Resident #172. Resident #172 was admitted to the facility on October 14, 2011, with diagnoses to include Diabetes Mellitus 2, Hypertension, Hyperlipidemia, Cataract, Hyperkalemia, Hypothyroidism impulse disorder Alzheimer's disease, Peripheral vascular disease, and Osteoarthritis. A review of the Assessment section and the Miscellaneous section record in EHR (electronic health record) on 10/9/20 showed the Pharmacy Drug Regimen Review information was not available. There was no evidence that Resident #172's record was reviewed at least once a month by a licensed pharmacist from January 2020, to May 2020 [5 months]. During a face-to-face interview conducted on October 13, 2020, at approximately 10:15 AM with Employee #2. The employee acknowledged the findings, and stated, "They were not place in the PCC [Point click care] system."	L 128	**4. Monitoring corrective action:** Director of Nursing / Designee will review report and present weekly during risk management meetings. Report will be forwarded to Quality Assurance Committee monthly x 3.	12/11/20

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L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to provide housekeeping services necessary to maintain a safe, clean and comfortable environment, as evidenced by torn chairs in one (1) of 33 resident's rooms and in one (1) of two (2) television (TV) rooms on the fourth floor, and bulk trash that was piled up in an area located next to the parking lot. Findings included ... During an environmental walkthrough of the facility on October 2, 2020, between 9:51 AM and 1:00 PM the following were observed: 1. One (1) of one (1) chair in resident room's #415A and one (1) of four (4) chairs in the TV room on 4 South were torn throughout. 2. Bulk trash such as mattresses, broken medication cart, chairs, sofas, small trash cans, and different types of defective equipment were stacked on the outside of the building, next to the parking lot and presented an environmental hazard to the community and a harborage site for pests. These findings were acknowledged by Employee #18 on October 2, 2020, at approximately 3:30	L 410	**1. Corrective action for the resident affected:** Torn chair in room 415A was immediately disposed and replaced. Resident in room 415A did not suffer any negative outcome. 4-South television room chair identified was removed immediately and replaced with new furniture set on 10/24/2020. Identified bulk trash was removed 10/09/2020. All residents residing in the facility did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Housekeeping Supervisors conducted facility wide round to ensure torn chairs or defective furniture were removed from resident care area and that the environment is free of trash or environmental hazard. No other issue of torn or defective furniture and environmental hazard were identified.	12/11/20 12/11/20

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L 410	Continued From page 21 PM and/or Employee #1 on October 7, 2020, at approximately 2:15 PM.	L 410	**3. Measures to prevent recurrence:** Facility Operations Director will in-service house-keeping and maintenance staff on the importance of keeping the environment safe, clean, comfortable, homelike and free of hazard. Assistant Maintenance Director will conduct daily round to ensure there are no torn or defective furniture in resident care area, trash are being picked up weekly or as needed to prevent trash accumulation, and defective or broken furniture / equipment pilling in the parking lot to prevent environmental hazard. Findings will be reported during daily Directors/Department heads' meeting. **4. Monitoring corrective action:** Facility Operations Director will submit report of findings monthly x 3 to Quality Assurance Committee.	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by a loose door that failed to close as intended, a broken temperature gauge and a broken temperature adjustment knob from one (1) of two (2) food warmers, and two (2) of six (6) slats from one (1) of one (1) walk-in freezer that were torn. Findings included ... 1. The access door to one (1) of two (2) food warmers was loose and failed to close as intended. 2. The temperature gauge and the temperature adjustment knob from one (1) of two (2) food warmers were broken. 3. Two (2) of six (6) slats in the walk-in freezer were torn. During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	L 442		12/11/20

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L 410	Continued From page 21 PM and/or Employee #1 on October 7, 2020, at approximately 2:15 PM.	L 410		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by a loose door that failed to close as intended, a broken temperature gauge and a broken temperature adjustment knob from one (1) of two (2) food warmers, and two (2) of six (6) slats from one (1) of one (1) walk-in freezer that were torn. Findings included ... 1. The access door to one (1) of two (2) food warmers was loose and failed to close as intended. 2. The temperature gauge and the temperature adjustment knob from one (1) of two (2) food warmers were broken. 3. Two (2) of six (6) slats in the walk-in freezer were torn. During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	L 442	**1. Corrective action for the resident Affected:** Loose and failed food warmer access door was repaired to function as intended. Identified food warmer broken temperature gauge and temperature adjustment knob have been replaced and food warmer is functioning as intended. Torn slats of the walk-in freezer were removed and replaced with new set. Residents did not suffer any negative Outcome.	12/11/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: _____ B. WING _____	10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH	901 FIRST STREET NW WASHINGTON, DC 20001

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L 538	Continued From page 22	L 538		
L 538	3270.3 Nursing Facilities Upon oral and written notification of discharge, the nursing facility shall provide to the resident and his or her representative: This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 43 sampled residents, facility staff failed to notify the responsible party of Resident #149's refusal to have his weight obtained by staff. Findings included... Resident #149 was admitted to the facility on February 8, 2018, with diagnoses that included Cirrhosis, End Stage Renal Disease (ESRD), Dementia, Seizure Disorder, Asthma and Respiratory Failure. Review of the Quarterly Minimum Data Set (MDS) dated August 17, 2020, showed in Section C (Cognitive Pattern), Resident #149's Brief Interview of Mental Status (BIMS) score was "7", indicating severe cognitive impairment and has a responsible party. The resident's weight was left blank under section K0200 (Height and Weight) on the MDS dated 5/17/20 and 8/17/20. Review of the Resident's weight record on October 2, 2020, revealed the following: 2/7/2020 178.4 Lbs [pounds] 1/15/2020 176.1 Lbs 12/9/2019 175.7 Lbs 11/5/2019 173.2 Lbs 10/11/2019 176.4 Lbs 9/13/2019 174.2 Lbs	L 538	**1. Corrective Action for the residents Affected:** Resident #149 was re-assessed on 10/07/2020 and re-encouraged to be weighed but refused. Resident #149 care plan has been updated on 10/07/2020 with refusal to be weighed. Employees #4 and #11 were counseled regarding failure to notify the responsible party of resident #149's refusal to have his weight obtained by staff. Resident #149 did not suffer any negative Outcome. **2. Identification of others with potential to be affected:** Residents residing in the facility have the potential to be affected. Nurse managers conducted medical record audit to identify residents that have refused care and responsible party/family member needed to be notified. No other residents were identified as being affected.	12/11/20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 538	Continued From page 23 The aforementioned weight record shows that the resident's last weight was obtained on 2/7/2020. Review of the progress notes showed the following: "8/18/2020 at 16:48 [4:48 PM] ...Quarterly Review- Resident's last weight recorded 2/7/2020- 178.4 [pounds]. He has not allowed the staff or this writer to weigh him. Therefore, weight status is undetermined for 30, 90 and 180 days. Resident was again approached today for consent to be weighed, but stated 'that's a stupid question'. He receives regular, regular Texture diet and consumes 50 - 100% of meals per nursing. No pressure wounds cited at this time." Review of the care plan last updated on August 8, 2020, showed: "6/1/2020-Resident declines weight monitoring since March 2020." "8/18/2020- Resident continues to decline weight monitoring despite education." There was no evidence in the clinical record to show that facility staff notified the resident's responsible party of his refusal to have his weight taken since February 2020. During a face-to-face interview conducted on October 7, 2020, at 11:56 AM with Employee #4 and Employee #11, both acknowledged the findings.	L 538	**3. Measures to Prevent Reoccurrence:** Staff Development Director will provide in-service training to inter-disciplinary team members (IDT) regarding facility's policy on notifying responsible party when there is refusal of care related issues or any change in resident condition with emphasis on residents' refusal to be weighed by staff. Assistant Director of Nursing/Designee will conduct weekly audit x 4 and monthly x 3 to ensure that residents' responsible parties are notified of care related issues including refusals. Report will be forwarded to the Director of Nursing. **4. Monitoring Corrective Action:** Director of Nursing will review report and present during weekly risk meeting. Report will be forwarded Quality Assurance Committee monthly x 3.	12/11/20