

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD02-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ (X3) DATE SURVEY COMPLETED 05/06/2015
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NAME OF PROVIDER OR SUPPLIER UNIQUE RESIDENTIAL CARE CENTER 901 FIRST STREET NW WASHINGTON, DC 20001	
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L 000	Initial Comments  A Licensure 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 Dressing 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 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)	L 000		

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L 000	Continued From page 1	L 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.	
L 001	mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MIN - 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 Pm - As needed Pt - Patient Q - Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC - Special Care Center TAR - Treatment Administration Record Sol - Solution	L 001	Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. 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 and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such	
L 001	3200.1 Nursing Facilities	L 001		

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(X4) ID PREFIX TAG <b>L 001</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>L 001</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
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<p>L 001 Continued From page 2</p> <p>as, equal access to waiting 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</p> <p>Facility staff failed to inform Resident #226 at the time of admission of their rights, all rules and regulations governing resident conduct and responsibilities.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>B. 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, Procedures, and Programs) for one (1) resident with a terminal diagnosis and received hospice care. Resident #194.</p> <p>The findings include:</p>		<p><b>A.</b></p> <p><b>3211.1 Nursing Facilities</b></p> <p>1. URCC informed resident #226 of her/his rights on 7/9/15</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>4. Monitoring Admission agreement is a component of the QA/QI Program. Information is presented to the QA committee.</p>	
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L 001 Continued From page 3	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. C. 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."	L 001	<b>B.</b> <b>3200.1 Nursing Facilities</b> 1. A review of resident #194's clinical record was conducted. A modification for the MDS was completed. 7/9/15 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.
L 001 Continued From page 3	C. Psychosocial needs and behavior documentation is a component of the social services department monitoring tool. This information is presented to the QA/QI committee. 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.	L 001	<b>C.</b> <b>3200.1 Nursing Facilities</b> 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.

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L 001	Continued From page 4 L 001		<p>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." 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</p>
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L 001	<p>Continued From page 5</p> <p>L 001</p> <p>room while the nurse manager and the surveyor were having a conference used verbal expletives and threatened what he/she was going to do.</p> <p>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. "</p> <p>On April 20, 2015 the following care plans which identified behavior problems were updated:</p> <p>Problem: The " Exhibits risks for violence directed to others related to verbal and physical abuse, such as threatening, cursing &amp; screaming. Actions Planned/Taken- to assist resident identify feelings/coping strategies by providing counseling as needed.</p> <p>Problem:Resists medications, injections and ADL assistance. Actions/Planned/Taken- to Assess expectations, cognitive status, attitude, motivation, lack of understanding, pain, intolerance/etc.</p> <p>Problem:Expresses persistent anger and possible frustration due 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</p> <p>Problem: Verbally and physically threatening to ...his/her roommate ...</p> <p>Actions/Planned/Taken-4/30/2015 Psychiatric consult. Moved to another room.</p>			
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L 001	<p>Continued From page 6</p> <p>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) 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.</p> <p>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.</p> <p>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.</p>	L 001		
L 052	<p>3211.1 Nursing Facilities</p>	L 052		

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	<p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers;</p> <p>(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;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(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;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p>	L 052	
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L 052 Continued From page 8	(A) Assistance, if needed, with daily hygiene, including oral care; and (B) Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. 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 sufficient nursing time was given to 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: Facility staff failed to ensure sufficient nursing time was consistently given to 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 determine 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	L 052	A. 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 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.
			3211.1 Nursing Facilities 7/9/15

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L 052	<p>Continued From page 9</p> <p>L 052</p> <p>of skin .... VI. Support Surfaces: 1. Use a higher-specification mattress rather than standard facility mattress for residents at risk. "</p> <p>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 (Alleyn) on top BID [twice a day] and Sacral Wound: NS [Normal Saline] WTD [Wet to Dry] dsq [dressing] changes to sacral wound BID. "</p> <p>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.</p> <p>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 Fasciomy, HTN [Hypertension], Status Post Hypomagnesemia, DM [Diabetes Mellitus], AKI [ Acute Kidney Insufficiency], Stage 4 Sacral Wound.</p>	
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L 052	Continued From page 10	L 052	

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 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

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L 052	Continued From page 11 L 052 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: " (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. "	L 052	
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L 052	Continued From page 12	L 052	<p>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. "</p> <p>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] Prosorice TID [three times a day] for nutrition support and to promote wound healing. "</p> <p>The resident was noted to be receiving Mag 64 po daily, Prosorice Liquid -30 ml po three times a day and Vitamin D3 50,000 units ' po one day per week for 12 weeks.</p> <p>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 administered to Resident #64 ' s buttocks as needed after each incontinence episode every shift as per the physician's order.</p> <p>According to a " Daily Skilled Nurse ' s Note " dated December 1, 2014 revealed: " T&amp;R Comments/Concerns Day Shift) revealed: " T&amp;R</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0010</b>	A. BUILDING:  _____  B. WING  _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
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L 052	Continued From page 13 L 052 [Turned and positioned] [every] 2 (two) hours. Treatment to wounds done as ordered .... Reddened area on left buttocks opened - 3 1/2 x 1 1/2 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 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 (Antimicrobial Dressing) gauze, Dermarite bordered, for plain x-ray - R/O [ Rule out] Osteomyelitis.		
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE <b>UNIQUE RESIDENTIAL CARE CENTER 901 FIRST STREET NW WASHINGTON, DC 20001</b>		
(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	

L 052	Continued From page 14	L 052	<p>(X4) ID PREFIX TAG</p> <p>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</p> <p>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.</p> <p>MD (Medical Doctor) Notes Continued:</p> <p>December 10, 2014- 1 PM- Patient seen today has multiple wounds on different sites (hospital acquired)</p> <p>1. Rt. Hand open wounds (non-pressure) ...</p> <p>2. Rt lower extremity pressure ulcers (two), Stage 4- Full thickness, " + " slough, [increased] pink tissue, moderate serous drainage. Plan: Xeroform dressing</p> <p>3. Sacral pressure ulcer- Stage 4, " + " undermining, " + " slough, moderate serous drainage. Plan: Santyl and Solofte Phalt Packing.</p> <p>4. Left heel eschar- Unstageable, Float, Skin prep daily</p> <p>December 17, 2014- 1PM- Patient seen today, has multiple wounds on different sites.</p> <p>1. Rt hand necrotic wounds (non-pressure)</p> <p>2. Sacral Pressure Ulcer- Stage 4, " + " [increased] slough- minimal, moderate serous drainage,</p>
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(X4) ID PREFIX TAG  L 052	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 L 052  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  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	ID PREFIX TAG  L 052	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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L 052	<p>Continued From page 16</p> <p>identified; left buttock wound and left heel not identified.</p> <p>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. "</p> <p>The nurse ' s admission progress notes documentation did not include the " sacral ulcer- Stage IV " that was identified on the admission assessment form.</p> <p>According to the facility's " Weekly Wound Healing Record " identified the following wound assessments:</p> <p>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.</p> <p>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.</p> <p>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: Serous, Wound Bed- Pink/Beefy Red.</p>	L 052		
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	L 052	Continued From page 17	<p>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)</p> <p>2014- Site/Location: Left Buttock Pressure Ulcer- Stage 3- 3 1/2 x 1 1/2 cm, 0 depth, Exudate Type: None, Wound Bed- Pink/Beefy Red</p> <p>A review of the clinical record for Resident #64 revealed an alteration in skin integrity to the left 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 ensure sufficient nursing time was given consistently to 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.</p> <p>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.</p> <p>A face-to-face interview was conducted with Employee #14 on May 6, 2015 at approximately</p>
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<p>L 052</p> <p>Continued From page 18</p> <p>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.</p> <p>B. Based on observation, record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to ensure one (1) resident's Peripherally Inserted Central Catheter (PICC) line was flushed and monitored in accordance with the attending physician's order. Resident #226.</p> <p>The findings include:</p> <p>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 ... "</p> <p>1a. Facility staff failed to flush a PICC line in accordance with the physician ' s orders for Resident #226.</p>	<p>L 052</p>	<p>1A.</p> <p>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.</p> <p>2. A review of all residents, was conducted. No other resident had a PICC line.</p> <p>3. The nursing Staff were re-educated regarding the flushing protocol for PICC lines.</p> <p>4. Monitoring of documentation is a part of the QA/QI program and is presented in the QA/QI Committee meeting.</p>	<p>7/9/15</p>
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L 052	Continued From page 19	L 052
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L 052	<p>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. "</p> <p>A review of the Central-Line Catheter Protocol for 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. "</p> <p>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.</p> <p>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.</p> <p>1b. Facility staff failed to ensure sufficient nursing time was given to monitor Resident #226's PICC line according to physician orders.</p> <p>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</p>	<p>1b B</p> <p>3211.1 Nursing Facilities</p>
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7/9/15	<p>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.</p> <p>2. A review of the residents at URCC was conducted. No other resident was impacted by this practice.</p> <p>3. The nursing staff were re-educated regarding monitoring and measuring the PICC line.</p> <p>4. Monitoring of documentation is a part of the QA/QI Program and is presented in the QA/QI committee.</p>	<p>1b B</p> <p>3211.1 Nursing Facilities</p>
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L 052	Continued From page 20 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 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. C. Based on observation and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to ensure sufficient nursing time was given 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 remove 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	L 052	<b>C.</b> <b>3211.1 Nursing Facilities</b> 1. Bandage Scissors were obtained for future dressing change for the resident #180. The resident was not impacted by this practice. 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.
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L 052 Continued From page 21	L 052 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 dietitian /nutritionists evaluate weight loss/gain ...The dietitian will evaluate the residents condition and make recommendations as needed. Recommendations may include the following: re-weigh the resident immediately for evaluation of true weight, 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. 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	3211.1 Nursing Facilities D. 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.
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L 052	<p>Continued From page 22</p> <p>150 lbs.</p> <p>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/nutritionist will evaluate weight loss/gain and make recommendations immediately to determine true weight.</p> <p>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.</p>	L 052		
L 099	<p>3219.1 Nursing Facilities</p> <p>Food and drink shall be clean, wholesome, free 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:</p>	L 099		

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L 099	Continued From page 23 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.	L 099	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.	7/9/15
L 167	Each facility shall comply with all applicable District and federal laws, regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute 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	L 167	4. Monthly Sanitation Audits are conducted by The 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.	



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NAME OF PROVIDER OR SUPPLIER  UNIQUE RESIDENTIAL CARE CENTER 901 FIRST STREET NW WASHINGTON, DC 20001		
(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>		

(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) COMPLETE DATE
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L 167	<p>Continued From page 24</p> <p>foot during wound treatment. Residents' #5 and #180</p> <p>The findings include:</p> <p>1. Facility staff failed to decrease possible cross contamination of food as evidenced by using bare hands to serve Resident # 5 his/her food.</p> <p>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.</p> <p>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. "</p> <p>Facility staff failed to decrease the spread of infection as evidenced by using his/her bare hands to prepare a resident food.</p> <p>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.</p> <p>A wound treatment observation was conducted on May 4, 2015 at approximately 10:30 AM with Employee #12. The following occurred:</p> <p>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.</p> <p>Employee #12 failed to place a</p>	L 167	<p><b>3227.18 Nursing Facilities</b></p> <p>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.</p> <p>2. A review of other staff preparing meals for residents was conducted. No other resident was impacted by this practice.</p> <p>3. The nursing staff was re-educated regarding preparation of meals.</p> <p>4. Monitoring the meal service is a component of the resident advocacy program. This information is presented in the QA/QI committee.</p> <p><b>2</b></p> <p>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.</p> <p>2. A review of nursing staff conducting treatment was conducted. No other resident was impacted by this practice.</p> <p>3. The nursing staff were re-educated regarding treatment administration particularly as it pertains to infection control.</p> <p>4. Monitoring treatment administration and infection control is a component of the QA/QI program and is presented in the QA/QI committee.</p>	7/9/15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0010</b>	A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNIQUE RESIDENTIAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 FIRST STREET NW WASHINGTON, DC 20001</b>	
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L 167	Continued From page 25 L 167  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.			
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