STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	R-C 12/15/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Revisit Survey was conducted at this facility on December 14-15, 2022 as a follow up to the recertification survey of September 26, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 214 and the survey sample included 30 residents. The following incidents were investigated during this survey: DC00011315 and DC00011319 Federal and/or Local deficiencies were cited related to the investigation(s) of : DC00011319 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia	{F 000}	Unique Rehabilitation and Health 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 on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 1-11-2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1	{F 000}		

DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic

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{F 000}	Continued From page 2 Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	{F 000}		
{F 550} SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	{F 550}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#1 was assessed by the Licensed nurse on 12/21/22 and ensured that the resident's privacy and dignity are maintained. Resident suffered no negative outcomes. Employee #3 was educated on 1/7/23 by the Staff Educator on importance of maintaining Resident rights, dignity, and privacy. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** A one-time house wide audit was completed on 12/19/22 by the (SW and IDT) to ensure residents rights, dignity and privacy were maintained. No other residents were affected.	

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{F 550}	Continued From page 3 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 30 sampled residents, facility staff failed to ensure that one resident was provided privacy during ADL (activities of daily living) care. Resident #1. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will provide an in-service [to] all staff on resident rights including maintaining privacy and dignity ...During grand rounds, staff will conduct a house wide audit to ensure that resident privacy and dignity are maintained during care ..."	{F 550}	**3. MEASURE TO PREVENT REOCURRENCE:** Education was completed for all IDT and clinical staff by the Staff Educator/designee on 01/09/23. to ensure that resident rights, dignity, and privacy are maintained. **4. MONITORING CORRECTIVE ACTION:** Social Work Directors or designee will audit one floor (north and south units) per week to ensure that resident's privacy and dignity are maintained. This audit will be completed weekly times four (4) and monthly times three (3). Negative findings will be corrected upon discovery. All findings to be reported to the monthly QAPI for further recommendations. Date of Compliance: 01/09/2023	

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{F 550}	Continued From page 4 Resident #1 was admitted to the facility on 09/03/22 with multiple diagnoses that included: Dementia, Glaucoma and Muscle Weakness. A Quarterly Minimum Data Set (MDS) dated 12/08/22 showed facility staff coded: moderately impaired cognition and required extensive assistance with one-person physical assist for personal hygiene. During a tour of unit 1 south on 12/14/22 at 10:36 AM, the following was observed from the hallway as the surveyor walked by room 117: Resident #1 was lying in bed with his incontinence brief exposed to anyone walking by the room, as Employee #3 (Certified Nurse Aide/CNA) was giving him a bed bath. The privacy curtain was not pulled, and the door was open. During a face-to-face interview conducted at the time of the observation, Employee #3 was asked why she did not pull the curtain to ensure that Resident #1 was provided with privacy, the employee stated, "I just started to get him washed and was helping his roommate too." It should be noted that Employee #3 signed her name to attest that she received the facility's in-service training on "Resident Rights" that was conducted on 10/07/22. DCMR 3269.1d	{F 550}		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	{F 609}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The incident was reported on 12.6.22. The delay in reporting did not have any impact on the resident's condition. A head-to-toe assessment was done by the licensed nurse on 12.21.22 and the resident suffered no negative outcome from this delay.	

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{F 609}	Continued From page 5 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, facility staff failed to report an unusual incident where one resident was found unresponsive in the facility's courtyard to the State Agency in a timely manner. Resident #2. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will in-service all staff and leadership to ensure the	{F 609}	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee conducted a house wide audit on 12/21/22 of all incidents from 11/25/22 to 12/21/22 to ensure that all incidents that meet Federal and State reporting criteria have been reported to the DOH in a timely manner and investigated thoroughly. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed for the Inter Disciplinary Team and clinical staff responsible for incident reporting and investigations This education was completed on 12.31.22 by Staff Educator/designee to ensure every incident that meets Federal and State reporting criteria have been reported to the DOH in a timely manner and has an appropriate investigation, with statements as applicable to the incident. Going forward all incidents will be reviewed by the DON and Administrator prior to its conclusion. **4. MONITORING CORRECTIVE ACTION:** LNHA/ Designee will conduct an audit of incident report forms, weekly for four (4) weeks and monthly for three (3) months to ensure incidents reported timely and are thoroughly investigated. Results of finding will be forward to QAPI for review and recommendations. Date of Compliance: 01/09/2023	

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{F 609}	Continued From page 6 facility implements ... reporting of unusual incidents to the appropriate law enforcement entity in a timely manner ... will conduct an audit of incident reports forms ... weekly for four weeks ..." Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition; independent for locomotion off the unit; no functional impairment in range of motion; and did not use any mobility devices. 11/25/22 at 10:48 PM "Nurses Note ...Resident returned from LOA (leave of absence) at 9:02pm...Resident ambulates to and from courtyard at this time with no distress noted ..." 11/25/22 at 11:02 PM "Nurses Note ...At 10:05pm resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair at the court yard. However there was presence of pulse and breathing. Resident was wheeled to her room and placed on her bed ...Resident was placed on 15 liters oxygen via non rebreather mask ... [Doctor] was notified and order was given to give resident 0.4 mg /ml (milligrams/milliliters) of Naloxone (medicine that rapidly reverses an opioid overdose). Resident became verbally responsive on administration of the first dose ..."	{F 609}		

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{F 609}	Continued From page 7 A Facility Reported Incident (FRI) received by the state agency on 12/07/22 documented, "Submitted On: Dec 6, 2022, 06:36 PM EST (Eastern Standard Time) ... Per charge nurse, resident returned from LOA at about 9 pm on 11/25/2022 in a stable condition. At 10:05pm, resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair in the court yard. However, there was presence of pulse and breathing. Resident was escorted to her room in wheelchair and placed on her bed. Resident was assessed ...Resident was placed on 15 liters oxygen via non rebreather mask ... [Doctor] was notified and ordered 0.4 mg /ml of Naloxone. Resident became verbally responsive on administration of the first dose. She could not verbalize what happened. MD (medical doctor) was made aware of resident's response and ordered to monitor resident 's vital signs every 2 hours x 2 days and notify MD of any abnormalities ..." The evidence showed that this unusual incident occurred on 11/25/22; however, the facility did report this incident to the State Agency until 12/06/22, 11 days later. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employees #1 (Administrator) and #2 (Director of Nursing/DON) were asked why Resident #2's unusual incident was not submitted timely to the State Agency. The employee's acknowledged the finding and made no comments.	{F 609}		
{F 610} SS=D	DCMR 3232.4 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	{F 610}		

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{F 610}	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, facility staff failed to investigate an unusual incident in which a resident was found unresponsive in the facility's courtyard. Resident #2. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will in-service all staff and leadership on the Abuse Policy and procedure to ensure the facility implements its policy on properly investigating any unusual incident ..." Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic	{F 610}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The investigation for the incident for Resident #2 was completed on 12.30.22 and statements were obtained from the applicable employees. The information obtained through the investigation did not have any impact on the resident's condition. A head-to-toe assessment was done by the licensed nurse on 12.21.22 and the resident suffered no negative outcome from this delay. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee conducted a house wide audit on 12/21/22 of all incidents from 11/25/22 to 12/21/22 to ensure that all incidents that meet Federal and State reporting criteria have been reported to the DOH in a timely manner and investigated thoroughly. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed for the Inter Disciplinary Team and clinical staff responsible for incident reporting and investigations This education was completed on 12.31.22 by Staff Educator/designee to ensure every incident that meets Federal and State reporting criteria have been reported to the DOH in a timely manner and has an appropriate investigation, with statements as applicable to the incident. Going forward all incidents will be reviewed by the DON and Administrator prior to its conclusion.	

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{F 610}	Continued From page 9 Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition; independent for locomotion off the unit; no functional impairment in range of motion; and did not use any mobility devices. 11/25/22 at 11:02 PM "Nurses Note ...At 10.05pm resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair at the courtyard. However, there was presence of pulse and breathing. Resident was wheeled to her room and placed on her bed ...Resident was placed on 15 liters oxygen via nonrebreather mask ... [Doctor] was notified and order was given to give resident 0.4 mg /ml (milligrams/milliliters) of Naloxone (medicine that rapidly reverses an opioid overdose). Resident became verbally responsive on administration of the first dose ..." A Facility Reported Incident (FRI) received by the state agency on 12/07/22 documented, "Submitted On: Dec 6, 2022, 06:36PM EST (Eastern Standard Time) ... Per charge nurse, resident returned from LOA (leave of absence) at about 9 pm on 11/25/2022 in a stable condition. At 10:05pm, resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair in the courtyard. However, there was presence of pulse and breathing. Resident was escorted to her room in wheelchair and placed on her bed. Resident was assessed ...Resident was placed on 15 liters oxygen via non rebreather mask ...[Doctor] was notified and	{F 610}	**4. MONITORING CORRECTIVE ACTION:** LNHA/ Designee will conduct an audit of incident report forms, weekly for four (4) weeks and monthly for three (3) months to ensure incidents reported timely and are thoroughly investigated. Results of finding will be forward to QAPI for review and recommendations. Date of Compliance: 01/09/2023	

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{F 610}	Continued From page 10 ordered 0.4 mg /ml of Naloxone. Resident became verbally responsive on administration of the first dose. She could not verbalize what happened. MD (medical doctor) was made aware of resident's response and ordered to monitor resident 's vital signs every 2 hours x 2 days and notify MD of any abnormalities ..." Review of the facility's FRI binder and packet for this unusual incident showed no documented evidence that an investigation was conducted. There were no statements from the staff who first observed Resident #2 "unresponsive to verbal and tactile stimulation"; no statement from any of the three courtyard monitors on shift at the time of the incident; and no statement from any other residents who were present in the courtyard at the time of the incident. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employee #1 (Administrator) stated, "All incidents are reviewed by the Administrator, Director of Nursing (DON) and QA (Quality Assurance) for interviews and completeness before going to DOH (Department of Health)." When asked why there was no documented evidence that an investigation was done for Resident #2's unusual incident, Employee #1 made no comment.	{F 610}		
F 623 SS=D	DCMR 3232.2 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#6 and #8 suffered no negative outcome from this deficient practice. Upon discovery, the missing details found on the form that was issued to the resident was completed and given to the Resident/RP on 12/20/22.	

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F 623	Continued From page 11 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** A house wide audit was done on 12/23/22 for all residents to whom the bed hold notice was issued since 12/05/22. Any negative findings were corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed by the Staff Educator/Designee for Medical Records personnel admissions manager, and clinical staff on 12/15/22 to ensure the bed hold policy is completed accurately and uploaded in the Electronic Health Record. Going forward all the bed hold notices issued will be reviewed by the Admissions Manager daily to ensure accuracy and completion and any negative findings will be rectified immediately. **4. MONITORING CORRECTIVE ACTION:** Administrator/Designee will audit residents who are transferred or discharged to the hospital to ensure that resident/responsible parties are notified and provided with a completed copy of the bed hold policy (6-108). This audit will be completed weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. Date of Compliance: 01/09/2023	

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 13 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, facility staff failed to document/record the specific reason(s) for the notice, the date of discharged, transferred, or relocated, and the destination on the notice before transfer (6-108) form for one (1) resident and failed to record the destination and the correct number of bed-hold days on the 6-108 form for one (1) resident. Residents' #6 and #8. The findings included... "Reserved Bed Day- a day for hospitalization or therapeutic leaves of absence, when provided for in the resident's plan of care and when there is a reasonable expectation that the resident will return to the nursing facility. Reserved bed days may not exceed a total of 18 days during any 12-month period that begins on October 1st and ends on September 30th. A therapeutic leave of absence includes visits with relatives and friends and leave to participate in a State-approved therapeutic and rehabilitative program." https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/	F 623		

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publication/attachments/DHCFStatePlanAttach4-19dPt1_0_0.pdf

1.Facility staff failed to include the specific reason(s) for the notice, the date of discharged, transferred, or relocated, and the resident's destination on the notice before transfer (6-108) form. Resident #6.

Resident #6 was admitted to the facility on 11/10/2022 with diagnoses that included Malignant Neoplasm of Brain, Seizures, Cerebral Edema, Paranoid Schizophrenia, Muscle Weakness, History of Falling.

Progress note dated 12/06/2022 at 10:31 AM showed, " ...resident is ambulatory on unit. At about 8AM, resident was observed with slurred speech and confusion and unable to ambulate. Reside was to answer simple questions or follow commands ...MD (medical doctor) was notified and ordered to transfer resident to the nearest ER (emergency room) for further evaluation for altered mental status ...Resident was assessed and transferred to [Hospital Name] ..."

Review of the DOH (Department of Health) Notice of Discharge Transfer or Relocation (6-108) form dated 12/06/2022 for Resident #6, showed, " ...(2) the specific reason(s) for this action is as follows; (3)You are scheduled to be discharged, transferred or relocated on or by (date); (4) your destination is; and (5) If you are being transferred to a hospital or the transfer is for therapeutic leave ... and the allotted space for the providers signature" were left blank.

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During a face-to-face interview on 12/15/2022 at 3:20 PM with Employees' #1, #2, #7, and #9; the findings were presented to the group, and they acknowledged that the aforementioned areas on the notice were left blank.

2. Facility staff failed to record the destination and the correct number of bed-hold days on the notice before transfer (6-108) form for Resident #8.

Resident #8 was admitted to the facility on 01/23/2019, with diagnoses that included Anemia, Major Depressive Disorder, Dementia, and Sudden Visual Loss of Left Eye.

Progress note dated 12/13/2022 at 22:44 (10:44 PM) showed, "Resident has vision loss to left eye, poor oral intake, MD (medical doctor) visited resident and ordered resident to be transferred to the nearest ER (emergency room). 911 was called and resident left the building at 15:01 pm (3:01 PM) to [Hospital Name] ..."

Review of the DOH (Department of Health) Notice of Discharge Transfer or Relocation form dated 12/13/2022 for Resident #8, showed, " ...(4) your destination is- to be determined. (5) If you are being transferred to a hospital or the transfer is for therapeutic leave ...Your available number of bed-holds is 18 days"...

Review of the Daily Census report for 12/13/2022 showed that Resident #8's payor type was Medicaid, and bed-hold days used was one (1).

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F 623	Continued From page 16 The resident's remaining bed-hold days was '17'. During a face-to-face interview on 12/15/2022 at 3:20 PM with Employees' #1, #2, #7, and #9 (Administrator, Director of Nursing, Educator and Director of Quality). The findings were presented to the group and then acknowledged by the group that the bed-hold days recorded on the form were incorrect. Cross Reference DCMR 3211.1	F 623		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, facility staff failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan as evidenced by: failed to administer two (2) residents blood pressure medications in accordance with the physician's orders. Residents' #4 and #189. The findings included: Review of the facility's Plan of Correction with a	{F 684}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** A Head-to-toe assessment was done for Resident #4 and Resident #189 by the Licensed nurse on 12.23.22 and suffered no negative outcomes from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who receive Midodrine Medication have the potential to be affected. Unit Managers/Designee conducted a house wide audit completed on 12/16/22 of all the residents on Midodrine medication to ensure that Midodrine is administered as prescribed by the physician. For negative findings discovered during the audit, disciplinary action with education was done for the staff.	

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{F 684}	Continued From page 17 compliance date of 12/05/22 documented, " ...Staff Educator/Designee will ... in-service on the importance of accurate medication administration as ordered by the physician. Education will be completed by 12/5/2022; and ... a house wide audit of all the residents ... on Midodrine medication weekly times four then three times monthly for three months ...Results will be given to QAPI monthly for recommendations to ensure services and medications are provided timely and accurately according to the physician's orders ..." 1. Facility staff failed to ensure that Resident #4 was administered his blood pressure medications in accordance with the physician's order. Resident #4 was readmitted to the facility on 10/11/2022 with multiple diagnoses that included: Hypotension, CHF (Congestive Heart Failure), Hypertensive Heart Disease, and End Stage Renal Disease. Review of Resident #4's medical record revealed the following: 10/28/2022 [physician's order] "Midodrine (for low blood pressure) HCl (Hydrochloride) Tablet 5 MG (milligrams), give 3 tablets by mouth 1 time a day every Mon (Monday), Tue (Tuesday), Wed (Wednesday), Thu (Thursday), Fri (Friday), Sat (Saturday), Sun (Sunday) for low blood pressure hold if BP (blood pressure) IS > (greater than) 130" Review of the Medication Administration Record (MAR) for December 2022 showed that on the following dates the resident was given Midodrine 5 MG outside of the directed parameters for administration:	{F 684}	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee conducted an in-service/education to all licensed nursing staff to ensure that Midodrine is administered as per the parameters ordered by the physician. Education was completed on 01/01/2023. **4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all the residents receiving Midodrine medication to ensure the parameters are followed as per the Physician's orders. This audit will be completed weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. Date of Compliance: 01/09/2023	

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{F 684}	Continued From page 18 12/10/2022 at 01:02 AM - BP 134/79 12/10/2022 at 11:12 PM - BP 134/76 12/11/2022 at 02:58 PM- BP 134/88 12/12/2022 at 11:57 AM -BP 138/67 It should be noted that the medication was scheduled to be administered at 9:00 am daily. According to the clinical record there were no blood pressure measurements taken at the time (09:00 AM) the nurses signed that Midodrine was administered to the resident. During a face-to-face interview conducted on 12/15/2022 at 1:17 PM, Employee #2 (Director of Nursing) reviewed the documentation and acknowledged the findings. 2. Facility staff failed to ensure that Resident #189 was administered his blood pressure medications in accordance with the physician's order. Resident #189 was readmitted on 10/05/2022 with multiple diagnoses that included: Orthostatic Hypotension, Hypotension, Hypertension, Hypertensive Chronic Kidney Disease, and End Stage Renal Disease. Review of Resident #189's medical record revealed the following: 10/08/2022 [physician's order] "Midodrine Tab 5MG (milligrams) Give 1 tablet orally three times a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) related to Essential (Primary)	{F 684}		

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{F 684}	Continued From page 19 Hypertension Hold if SBP (systolic blood pressure) > (greater than) 120MG/DL (milligrams per deciliter)" Review of the Medication Administration Record (MAR) for December 2022, showed that on the following dates, Resident #189 was given Midodrine 5MG outside of the directed parameters for administration: 12/08/2022 at 12:29AM - BP 127/74 12/08/2022 at 04:10PM - BP 124/69 12/08/2022 at 07:01PM - BP 127/66 12/10/2022 at 12:52AM - BP 138/80 12/10/2022 at 05:08PM - BP 132/69 12/10/2022 at 10:55PM - BP 128/70 12/13/2022 at 12:52AM - BP 134/79 12/13/2022 at 11:36AM - BP 125/66 It should be noted that the medication was scheduled to be administered at 08:00AM, 02:00 PM and 10:00 PM every Tuesday, Thursday, and Saturday. According to the clinical record, there were no blood pressure measurements taken at the time (08:00 AM, 02:00 PM, 10:00 PM) the nurses signed that Midodrine was administered to the resident. During face-to-face interview conducted on 12/15/2022 at 1:17 PM, Employee #2 (Director of Nursing) reviewed the documentation and acknowledged the findings. DCMR - 3211.1	{F 684}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	{F 689}		

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{F 689}	Continued From page 20 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, in two (2) of two (2) observations, facility staff failed to provide an environment free from accident hazards as evidenced by failing to keep medications out of the reach of ambulatory, cognitively impaired residents on two nursing units. Residents' #6 and #158. The findings included: 1.Facility staff failed to keep a blister pack of 13 tablets of Donepezil (medication used to treat dementia) out of residents reach on unit 1 south. During a tour of unit 1 south on 12/14/22 at 10:59 AM, the surveyor entered room 112 B to conduct a wound dressing observation. As the surveyor was entering the room, Employee #4 (Registered Nurse/RN) was observed passing out medications. At 11:20 AM, as the surveyor was walking out of room 122, a blister pack containing 13 tablets of Donepezil was observed on the hallway floor, as residents walked by. The surveyor picked up the medication and walked to the nurse's station, where the medication cart was observed parked, and Employee #4 was sitting.	{F 689}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No resident was affected due to this deficient practice. Resident #6 and Resident #158 received their scheduled medications with no negative outcome. Employee#4 and Employee#10 were educated on 12/14/22 and 12/20/22 respectively on medication administration, appropriate disposal and destruction of medications that are refused and appropriate storage of medications. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** A house wide audit was completed on 12/21/22 by Unit Managers to ensure all medications were safely stored. Any negative findings were corrected upon discovery **3. MEASURE TO PREVENT REOCURRENCE** Education was completed by the Staff Educator/designee for all licensed nurses on 01/01/23 on medication administration to ensure safe storage of medications and disposal/destruction of refused or contaminated medications. Going forward the Pharmacy will continue to monitor medication storage and administration; any findings will be corrected upon discovery. **4. MONITORING CORRECTIVE ACTION** Unit Managers will audit their respective units for accuracy of medication administration and storage. This audit will be done weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 01/09/2023	

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{F 689}	Continued From page 21 During a face-to-face interview conducted on 12/14/22 at 11:21 AM, it was brought to Employee #4's attention that a blister pack of medication was found on the floor, causing a hazard risk. Employee #4 stated, "I'm sorry. I didn't see when it fell." 2. Facility staff failed to maintain a safe environment during medication administration observation conducted on unit 3 South (secured unit with residents who have advanced dementia) as evidenced by leaving medications unattended on top of the medication cart. Residents' #6 and #158. According to Title 42 CFR § 483.45 Pharmacy services. "(h) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys." https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.45 During a medication observation on Unit 3 South on 12/14/2022 at approximately 11:20AM, Employee #10 (Registered Nurse, Supervisor) was observed preparing to give medications to Resident #6. At this time, an unlabeled disposable souffle cup containing 4 pills was observed on the medication cart. Employee #10 was asked who the medications belong to? She answered, [Resident #158]. Employee #10 then continued to prepare medications for Resident #6, locked the medication cart and proceeded to enter the room of Resident #6. While in Resident #6's room, Employee #10 was observed	{F 689}		

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{F 689}	Continued From page 22	{F 689}		

out of direct line of eyesight of the medications left on the cart. At the time of the observation two (2) residents were seated in close proximity to the medication cart.

During a face-to-face interview with Employee #10 during the medication observation, she acknowledged leaving the unlabeled medication cup containing a resident's medications unattended on the medication cart. She was asked why the opened, unlabeled medications were left unattended on the cart. She stated, "These were for [Resident #158], she refused her medications...I will go back to give them to her."

The Writer went to Resident #158's room. She was observed in her room asleep without any noted distress.

The Writer returned to the medication cart and asked Employee #10, What medications were in the unlabeled medication cup. She stated, "Depakote (used to treat Seizures, Bipolar), Finesteride (used to treat Benign Prostatic Hyperplasia in men), Nifedipine (used to treat High Blood Pressure) and Ferrous Sulfate (used to treat Iron Deficiency Anemia)."

There was no evidence that Employee #10 secured the medications in the souffle cup, they were not under direct observation of authorized staff, thus leaving the medication accessible to residents.

In addition, a review of the Medication Administration Record (MAR) on 12/14/2022 at approximately 2:35PM revealed Resident #158, did not have physician orders to receive Depakote, Finesteride, Nifedipine, or Ferrous

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UNIQUE REHABILITATION AND HEALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001

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{F 689}	Continued From page 23 Sulfate. During a face-to-face interview with Employee #10 and Employee #2 DON (Director or Nursing) at approximately 2:54PM, the Writer asked Employee #10 if she knew who the unattended medications belonged to? She stated, "[Resident #158]." Writer informed Employee #10 and Employee #2 that Resident #158's MAR was reviewed, and it was found that those medications were not ordered for her. Employee #10 stated, "I don't know how I got it mixed up." The Surveyor then asked the Employee #10 what happened to the medications that were unlabeled on the cart that you said belonged to Resident #158? Employee #10 stated, "I threw them away ... another Nurse gave her [Resident #158] meds when she woke up ..." DCMR 3211.1	{F 689}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	{F 755}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** A head-to-toe assessment was done by the licensed nurse for Resident#10 on 12.20.22, Resident#15 on 12.21.22, Resident#110 on 12.22.22 and they suffered no negative outcome from this delay. Employee #5 and Employee #6 were educated on 1/6/23 safely storing, logging in the narcotic log and documenting receipt of narcotics from the pharmacy. Licensed staff responsible completed a late entry to rectify the deficiency.	

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{F 755}	Continued From page 24 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for three (3) of 30 sampled residents and for two (2) of eight (8) nursing units, facility staff failed to account for the receipt, usage, administration, and reconciliation of controlled medications. Residents' #110, #10 and #15. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented," ...will conduct in-service for licensed nurses on the policy to ensure accurate narcotic counts are reconciled per the standards of practice ...ADON (Assistant Director of Nursing) or designee will conduct house wide audits of all narcotic counts and will audit the narcotic count log book to ensure narcotic count matches the logs weekly for four weeks ..." 1. Facility staff failed to account for the amount of	{F 755}	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** A house-wide audit was completed by Unit Managers on 12/17/22 for all medication carts to ensure Narcotics received are signed for, logged in correctly. This audit was completed on 12/17/22. Any negative findings were corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed by the Staff Educator/Designee for all licensed nurses on 1/1/23 for proper logging of new narcotics received by the pharmacy and ensuring they sign for it on receipt. Education included ensuring appropriate narcotic counts at the start and end of the shift with appropriate documentation on administration of narcotics. Going forward pharmacy will continue to monitor medication storage and narcotic logs on a monthly and report any negative findings. **4. MONITORING CORRECTIVE ACTION** Unit Managers will audit their respective units to ensure narcotics received by the pharmacy are properly signed for, logged and documented in the narcotic count sheet. This audit will be done weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 01/09/2023	

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{F 755}	Continued From page 25	{F 755}		

Clonazepam (medication used to prevent and treat seizures, panic and anxiety disorders) tablets received for Resident #110.

During a narcotic count on 12/14/22 at 11:23 AM on unit 1 north with Employee #5 (Registered Nurse/RN), a blister pack containing 30 tablets of Clonazepam 1mg (milligrams) was observed for Resident #110. The "Controlled Drug Administration Record ..." form that recorded the receipt of Resident #110's Clonazepam 1mg tablets documented, "date received 12/05/22" but failed to document, "amount received" or "signature" of the staff who received the medication.

At the time of the finding, Employee #5 was asked how she ensured that the amount of Clonazepam 1mg tablets being counted is what was received by the pharmacy on 12/05/22, she stated, "I am not sure who received the medication. We've just been counting what is in the [narcotic] box."

Resident #110 was admitted to the facility on 12/10/19 with diagnoses that included: Seizures, Anxiety Disorder and Schizophrenia.

Review of Resident #110's medical record revealed:

07/14/22 [physician's order] "Clonazepam Tablet 1 mg Give 1 tablet by mouth three times a day related to Anxiety Disorder"

The evidence showed that from 12/05/22 to 12/14/22, a total of 10 days, facility staff failed to account for the receipt and reconciliation of Resident #110's controlled medication,

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{F 755}	Continued From page 26	{F 755}		

Clonazepam 1 mg tablets.

2. Facility staff failed to account for the usage, disposition, administration, and reconciliation of Resident #10's Pregabalin (medication used to treat epilepsy and neuropathic pain) and Resident #15's Tramadol (narcotic pain medication).

Resident #15 was admitted to the facility on 09/19/22 with diagnoses that included: Pain, Liver Cell Carcinoma and Acute Kidney Failure.

A. During a narcotic count on unit 2 north on 12/14/22 at 11:32 AM with Employee #6 (Licensed Practical Nurse/LPN), the "Controlled Drug Administration Record ..." form for Resident #10's Pregabalin 300 mg tablets showed, " ...date/time 12/10/22 9 AM; dose administered 1 tab (tablet) ... admin (administered) by [Nurse signature] amount rem (remaining) 15", followed by a blank entry line then, " ...date 12/11/22 7 PM; dose administered 1 tab ... admin by [Nurse signature] amount rem 13".

There was no documented evidence to show the date, time or signature of the licensed staff who took out the 14th dose of Resident #10's Pregabalin 300 mg tablet.

During a face-to-face interview conducted at the time of the observation, Employee #6 stated, "I am not sure why there's a space on the form, I'll have to check with my unit manager."

Review of Resident #10's medical record showed:

11/17/22 [physician's order] "Pregabalin Capsule

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{F 755}	Continued From page 27 300 MG Give 1 capsule by mouth two times a day for pain" Medication Administration Record (MAR) for December 2022 showed that on 12/10/22 at 7:00 PM, a licensed staff documented a check mark and their initials to indicate that Pregabalin Capsule 300 MG was administered to Resident #10. The evidence showed that from 12/10/22 to 12/14/22, a total of 5 days, facility staff to to account for the usage, administration, and reconciliation of Resident #10's Pregabalin 300 mg capsules. B. During a narcotic count on unit 2 north on 12/14/22 at 11:32 AM with Employee #6, the "Controlled Drug Administration Record ..." form for Resident #15's Tramadol 50 MG tablets showed, that on 12/12/22 [at] 2 PM, dose administered 1 tab(tablet) ... admin by [Nurse signature] amount rem (remaining) 29". The next line showed, "amount rem 28", (indicating that a dose was removed by facility staff); however, there was no documented date/time, dosage amount or signature of who removed the medication. During a face-to-face interview conducted at the time of the observation, Employee #6 stated that he can't explain why Resident #15's "Controlled Drug Administration Record ..." form for Tramadol 50 MG was missing that vital information. The employee was further asked if he had noted this discrepancy when he conducted the narcotic reconciliation count at the start of his shift, Employee #6 stated, "I'll have to bring this to my unit manager."	{F 755}		

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{F 755}	Continued From page 28 Review of Resident #15's medical record showed: 12/05/22 [physician's order] "Tramadol Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for pain". On 12/09/2022 the medication was discontinued by the physician at 6:02 PM. Review of the December MAR showed that from 12/01/22 to 12/15/22, Resident #15 did not receive Tramadol 50 MG. It should be noted that, Resident #15's December 2022 MAR shows that Tramadol 50 mg was not administered. The Controlled Drug Administration Record showed that Tramadol was removed for the packing on 12/12/22 at 2:00 PM (3 days after it was discontinued) and from 12/12/22 to the date of this observation, another tablet of Tramadol 50 MG was removed from the packaging. During a face-to-face interview conducted on 12/15/22 at 2:20 PM with Employees #2 (Director of Nursing/DON) and #7 (Staff Educator), Employee #7 stated that no issues were found during their audits of the narcotic books/count that have been done so far. Both employees reviewed the "Controlled Drug Administration Record ..." forms for Residents' #110, #10 and #15 and made no further comments. DCMR 3224.3	{F 755}		
{F 770} SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i)	{F 770}		

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{F 770}	Continued From page 29 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, facility staff failed to provide laboratory services to meet a resident's needs. Resident #2. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...during morning meeting the clinical team will review all lab orders to ensure that labs are obtained in a timely order ... ADON (Assistant Director of Nursing) or designee will audit laboratory orders ... weekly for four (4) weeks ..." Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition.	{F 770}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #2 refused urine toxicology test. MD was made aware and asked to discontinue the order. Resident suffered no negative outcome. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** A house wide audit was done on 12.19.22 for the lab orders since 11.29.22 and any negative findings were corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed by Staff Educator/designee for all licensed nurses on 01/01/23 to ensure lab orders are entered and carried out appropriately. As a general practice, laboratory orders will be reviewed during daily clinical meetings. **4. MONITORING CORRECTIVE ACTION** ADON or designee will audit laboratory orders, weekly for four (4) weeks, monthly for three (3) months to ensure that laboratory services were provided in a timely manner per the standards of practice. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be addressed upon discovery. Date of Compliance: 01/09/2023	

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{F 770}	Continued From page 30 11/26/22 [physician's order] "Urine Toxicology in am (11/26/22) facility to collect and Lab will pick up) one time only for possible substance use" 11/26/22 at 12:29 PM "Nurses Note ...Writer place call for lab to pick up urine. and they said 'they will come and pick up the urine' but they didn't give specific time due to shortage of staff." 11/29/22 [physician's order] "Urine Toxicology one time only for possible substance abuse for 2 days" Treatment Administration Record (TAR) for November 2022 showed that on 11/26/22 and 11/30/22, facility staff documented a check mark and their initials to indicate that the task of obtaining a urine sample for toxicology was obtained for Resident #2. Although facility staff documented to obtaining Resident #2's urine for toxicology testing on 11/26/22 and 11/30/22, there was no documented evidence to indicate that the urine was picked up by the lab on either days. It should also be noted that during a review on 12/15/22, there was no documented urine toxicology results in Resident 2's medical record for November or December 2022. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employee #2 (Director of Nursing/DON) stated, "Urine toxicology takes a while. The urine has to get sent out to [Laboratory name] and it takes 7-10 days for the results to come back." When asked about the results of Resident #2's urine toxicology reports from 11/26/22 and 11/30/22, the employee stated that she would have to follow up.	{F 770}		

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{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	{F 842}	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The note for resident #2 was corrected with clarification of time of the visit. The resident suffered no negative outcome. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents visited by the Psychiatrist have the potential to be affected by this practice. An audit was completed on 12/24/22 to ensure that all notes entered since November 2022 by the Psychiatrist were documented for the time of the visit when the resident was in-house. There were no further negative findings. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/designee completed a 1:1 education with the Psychiatrist on 12/16/22 to ensure safe and accurate documentation practices. **4. MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers/designee to ensure that the notes entered by the Psychiatric practitioner reflect the time of the visit and ensure resident is present in house at the time of the visit. This audit will be done weekly for four (4) weeks, monthly for three (3) months. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be addressed upon discovery. Date of Compliance 01/09/2023.	

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{F 842}	Continued From page 32 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, facility staff inaccurately documented that a psychiatric evaluation was completed on a resident who was not present in the facility. Resident #2. The findings included: Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and	{F 842}		

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{F 842}	Continued From page 33 Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition. 11/24/22 [physician's order] "Resident may go LOA (leave of absence)" 11/24/22 at 11:32 AM "Nurses Note ... Resident ... out LOA with family member at 10:40am ...she will be return tomorrow on 11/25/22 ..." 11/25/22 at 2:24 PM "Physicians Progress Note Late Entry ... Physician follow-up Psychiatric Evaluation. Date of visit: 11/25/22. Subjective ...Reports mood as "good" and cites poor sleep and fatigue, but with improvement ... Appearance: Fairly groomed in street clothes, no apparent psychomotor agitation or depression. Orientation: Oriented to place, person, date ..." 11/25/22 at 10:48 PM "Nurses Note ...Resident returned from LOA (leave of absence) at 9:02pm ....Resident ambulates to and from courtyard at this time with no distress noted ..." The evidence showed that per the facility's documentation, Resident #2 was on LOA and out of the facility from 11/24/22 at approximately 10:40 AM until 11/25/22 at approximately 9:05 PM. However, on 11/25/22 at 2: 24 PM, the psychiatric physician documented to completing a follow-up evaluation on the resident. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employee #2 (Director of	{F 842}		

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{F 842}	Continued From page 34 Nursing/DON) reviewed the progress note, acknowledged the finding and made no further comment. DCMR 3231.12	{F 842}		