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 _____	04/29/2019

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

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F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Unique Rehabilitation and Health Center from April 17 through April 29, 2019. Survey activities consisted of a review of 63 sampled residents. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is 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: Abbreviations 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 CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	UNIQUE REHABILITATION & HEALTH CENTER DISCLAIMER FACILITY SUBMITS THIS PLAN OF CORRECTION UNDER PROCEDURES ESTABLISHED BY THE DEPARTMENT OF HEALTH IN ORDER TO COMPLY WITH THE DEPARTMENT'S DIRECTIVE TO CHANGE CONDITIONS WHICH THE DEPARTMENT ALLEGES ARE DEFICIENT UNDER STATE REGULATIONS RELATING TO LONG TERM CARE. THIS SHOULD NOT BE CONSTRUCTED AS EITHER A WAIVER OF THE FACILITY'S RIGHT TO APPEAL AND TO CHALLENGE TO ACCURACY OR SEVERITY OF THE ALLEGED DEFICIENCIES OR ANY ADMISSION OF ANY WRONG DOING.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephen Gbenle NHA.	Administration	5/31/2019.

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		

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)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
OD: Right eye
OS: Left eye
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
SCSA Significant change status assessment
Sol- Solution
TAR - Treatment Administration Record
Trach- Tracheostomy

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F 000	Continued From page 2	F 000	**Corrective action for the residents affected:**	
	TX- Treatment			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550	1. The resident #11 was assessed on 4/29.2019. Resident #11 there was no negative outcome by the deficient practice. The involved nursing employee was counseled for failing to knock on the resident's door and waiting for permission to enter the resident's room.	4/29/19
	§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.		**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Random audits completed by department heads on all shifts. No other resident was affected by this deficient practice. Typed postings were permanently posted on the door to knock and wait for permission before entry.	4/29/19
	§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.		**Measures to prevent reoccurrence:** 3. Staff Development Director/designee will provide in-service to facility staff to ensure staff facilitates the resident's right to receive respect and dignity by knocking on the resident's door and waiting for permission prior to entering the resident's room. Random audits will be completed by the unit managers weekly X4, than monthly X3. Results will be forwarded to the DON.	6/10/19
	§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility 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.		**Monitoring corrective action:** 4. DON will present result findings to the Quality Assurance Improvement Committee monthly for the next 3 months or until sustained compliance is achieved.	ongoing
	§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			

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F 550	Continued From page 3 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 an observation and staff interview for one (1) of 63 sampled residents, facility staff failed to facilitate the resident's right to receive respect and dignity by failing to knock on the resident's door and waiting for permission to enter the resident's room. Resident #11. Findings included . . . Resident #11 was admitted to the facility on November 14, 2016 with diagnoses which included Anemia, Hypertension, Hyperlipidemia, Non-Alzheimer's Dementia, Hemiplegia/Hemiparesis, Seizure Disorder and Depression. Review of the comprehensive Minimum Data Set (MDS) with a completion date of October 01, 2018 showed the resident with a Brief Interview for Mental Status (BIMS) score of 15 which is an indication that he is cognitively intact. Under section G0110 Activities of Daily Living (ADL) Assistance the resident requires extensive assistance from two (2) persons and limited assistance from 2 persons for transfer and dressing and personal hygiene, limited assistance from one (1) person for eating and for toilet use.	F 550		

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F 550	Continued From page 4 At approximately 3:39 pm on April 22, 2019 Employee #9, Certified Nursing Assistant (CNA) walked into Resident #11's room while this writer was interviewing the resident. The door to the room was open but the CNA never knocked on the door. When asked why he did not knock before entering the room he said, "I thought it was okay to enter without knocking because the door was open. I am sorry I should have knocked on the door and waited to enter." Employee #8 was informed of the occurrence during a face-to-face interview on April 23, 2019 at approximately 11:00AM and acknowledged the finding.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	**F-584** **Corrective action for the residents affected:** 1. The Therapeutic Nutrition drinks that were stored beyond their expiration date cited during the survey period was discarded immediately. **Identification of others with potential to be affected:** 2. All residents have to potential to be affected. All storage shelves were checked by housekeeping staff. No other expired therapeutic nutrition drinks were found. **Measures to prevent reoccurrence:** 3. Staff Development Director will educate housekeeping staff and nursing staff on checking all therapeutic nutrition drinks and other items for their expiration dates, how and when to discard these items. Environmental Director will complete audits of storage shelves weekly X4, than monthly X3.	4/29/19 4/29/19 6/10/19

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F 584	Continued From page 5 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by 16 of 16 Therapeutic Nutrition drinks that were stored beyond their expiration date. Findings included ... During an environmental tour of the facility on April 18, 2019, between 10:45 AM and 3:40 PM, 16 of 16 eight fluid ounce cartons of Ensure Clear Therapeutic Nutrition, stored on a shelf in the Clean room on unit 4 north, were expired as of	F 584	**Monitoring corrective action:** 4. Environmental Director will present to the Quality Assurance Improvement Committee monthly for the next 3 months.	ongoing.

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F 584	Continued From page 6 February 1, 2019. During a face-to-face interview on April 18, 2019, at approximately 10:50 AM, Employee #4 acknowledged the findings.	F 584	**F610-A** **Corrective action for the residents affected:** 1. The resident #DG1 was assessed on 4/29.2019. Resident was not harmed by the deficient practice. The clinical manager of the unit was counseled for the absence of documentation in resident #DGI and resident #90 medical record that showed failure that the incident was thoroughly investigated.	4/29/19
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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 interviews, the facility staff failed to thoroughly investigate an allegation of resident -to-resident abuse for four (4) of 63 sampled Resident's, #90, #177, #180 and #DG1. Findings included ...	F 610	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all residents with allegations of resident to resident abuse were audited to ensure that the facility thoroughly investigated an allegation of resident to resident abuse/altercation. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff regarding the facility policy when there is an allegation of abuse identified. Unit managers will conduct weekly audits X4, than monthly X3. Au8dit results will be forwarded to the DON **Monitoring corrective action:** 4. Abuse, abuse identification, prevention and reporting will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until 3 months of greater than or equal to 95 % compliance is achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ONGOING

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F 610	Continued From page 7 A review of the facility's allegations of abuse was conducted on April 24, 2019, at 3:00 PM with Employee #1. The review included the following incidents: A. An incident report dated March 15, 2019. "Titled, Abusive Resident ... incident description [Resident # 90] denies slapping his roommate [Resident #DG1]. There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. B. An incident report dated March 15, 2019. "Titled, Abusive Resident ... incident description [Resident # DG1] denies slapping his roommate [Resident #90]. There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. C. An incident report dated January 12, 2019. "Titled, Abusive Resident ... incident description [Resident # 180 denies being hit with Resident's walker [Resident #177]. There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the	F 610	**F610-B** **Corrective action for the residents affected:** 1. The resident #180 and #177 was not harmed by the deficient practice. The clinical manager of the unit was counseled for the absence of documentation in resident #180 and #177 medical record that showed failure that the incident was thoroughly investigated. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all residents with allegations of abuse or altercations were audited to ensure that the facility thoroughly investigated and allegations of resident to resident abuse/altercation. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff regarding the facility policy when there is an allegation of abuse identified. Unit managers will conduct weekly audits X4, than monthly X3. Au8dit results will be forwarded to the DON **Monitoring corrective action:** 4. Resident to resident abuse identification, prevention and reporting will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until 3 months of greater than or equal to 95 % compliance is achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/29/19 4/30/19 6/10/19 ongoing

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F 610	Continued From page 8 investigation) to show that the incident was thoroughly investigated. D. An incident report dated January 12, 2019. "Titled, Abusive Resident ... incident description [Resident # 177] denies purposely hitting Resident with her walker [Resident #180]. There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. On March 24, 2019, approximately at 5:30 PM, Employee #1 acknowledged the findings.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622	**F-622** **Corrective action for the residents affected:** 1. The resident #74, #129, #175, #204, #225, and #474. The facility cannot retroactively correct the deficiency. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. No other resident was affected by this deficient practice and evidenced by a review of residents who were discharged to other health care institutions from the facility in the past 90 days. A transfer/discharge checklist has been created.	4/29/19

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F 622	Continued From page 9 otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section.	F 622	**Measures to prevent reoccurrence:** 3. Staff Development Director will provide in-service to the nursing staff to follow the required resident transfer/discharge guidelines and utilize the transfer/discharge checklist. The interdisciplinary team will be re-educated on the discharge planning process, required documented discussion with the resident and their representative, a transfer/discharge checklist will be completed and reviewed for all residents with discharge potential, prior to finalizing the discharge. Audits of discharged residents will be conducted by the Social Service staff weekly X4, monthly X3. **Monitoring corrective action:** 4. Audits of the discharge/transfer process will be added as a social work quality indicator to ensure compliance until 3 consecutive months of greater than or equal to 95% compliance is achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	6/10/19 ongoing

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F 622	Continued From page 10 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for six (6) of 63 sampled residents, the facility staff failed to document the transfer information communicated to the receiving health care institution in six (6) residents medical record. Residents' #74, #129, #175, #204, #225 and #474.	F 622		

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F 622	Continued From page 11 Findings included... 1. The facility staff failed to document the transfer information communicated to the receiving health care institution on Resident #74's medical record. Resident #74 initial admission to the facility is on January 22, 2019, with diagnoses to include Anemia, Hypertension, Diabetes Mellitus, Malignant Neoplasm of Bladder, Atrial Fibrillation, Generalized Muscle Weakness, and Dementia without Behavioral Disturbance. A review of the Admission Minimum Data Set [MDS] dated February 9, 2019. Section C0500 [BIMS Summary Score] of "11" moderately impaired cognition which indicates, "Resident decisions poor: cues/supervision required". A review of the Physician's order dated January 25, 2019, directed "Send resident out to the nearest ER for Hematuria and Hypotension." A review of the Patient Transfer notes dated January 25, 2019, showed a lack of the following documented information: "contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident's diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status." The facility staff failed to ensure all information mentioned above was communicated to the	F 622		

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F 622	Continued From page 12 receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident #74 to the emergency room on January 25, 2019. A face-to-face interview was conducted on April 25, 2019, at approximately 10:00 AM with Employee#6. The employee acknowledged the finding. 2. The facility staff failed to document the transfer information communicated to the receiving health care institution on Resident #129's medical record. Resident #129 was initially admitted to the facility on November 2, 2018, with diagnoses which include Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Parkinsonism, Generalized Muscle Weakness, Major Depressive Disorder, Bipolar Disorder, and Schizophrenia. A review of the Significant Change Minimum Data Set [MDS] dated January 31, 2019. Section C0500 [BIMS Summary Score] of "7" severely impaired cognition which indicates, "Never/rarely make decisions". A review of the Physician's order dated February 18, 2019, directed "Send resident out 911 to nearest ER secondary to multiple seizures even after taking seizure medication and limited physical activities." The medical record lacked documentation to support the facility communicated the name of	F 622		

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F 622	Continued From page 13 the practitioner who is responsible for the care of the resident, resident's representative contact information, advance directive information, special instructions and precautions, and comprehensive care plan goals to the receiving health care institution for the transfer that occurred February 18, 2019. A face-to-face interview was conducted on April 25, 2019, at approximately 10:00 AM with Employee#5. The employee acknowledged the finding. 3. The facility staff failed to document the transfer information communicated to the receiving health care institution on Resident #175's medical record. Resident #175 was admitted to the facility on 1/13/17 with diagnoses which include Hypothyroidism, Types II Diabetes Mellitus without Complications, Major Depressive Disorders, Unspecified Glaucoma and Vascular Dementia with Behavioral Disturbance. Review of the medical record on 4/24/19 at 10:00 AM showed a Comprehensive Minimum Data Set dated 3/20/19, Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "7" which indicates severe cognitive impairment. Review of the physician's order dated 2/28/19 "Transfer resident to the nearest emergency room Altered Mental Status and Lethargy." Review of the resident's medical record failed to show information given to the receiving health care institution to include the following: contact	F 622		

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F 622	Continued From page 14 information of the practitioner responsible for the care of the resident, resident representative including contact information, advance directive information, special instructions, and comprehensive goals. Facility staff failed to provide evidence that all pertinent information (contact information of the practitioner, advance directive information, special instructions and comprehensive goals) was communicated to the receiving facility. During a face-to-face interview on 4/24/19 at 10:00 AM Employee #3 acknowledged the finding. 4.The facility staff failed to document the transfer information communicated to the receiving health care institution on Resident #204's medical record. Resident #204 was admitted to the facility on June 19, 2018, with diagnoses that included Hyperkalemia, Diabetes Mellitus, Hypertension, Parkinson's Disease, Dysarthria and Anarthria, Cerebrovascular Disease, Chronic Kidney Disease, Generalized Muscle Weakness, Disorientation and Dementia with Behavioral Disturbances. A review of the Significant Change Minimum Data Set [MDS] dated March 26, 2019. Section C1000 [Cognitive Skills for daily Decision Making] coded as "3" which indicates resident is Severely Impaired -never/rarely made decisions. Physician's Order dated January 25, 2019,	F 622		

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F 622	Continued From page 15 directed " Transfer resident to nearest ER for evaluation of head injury s/p [status/post] fall." A review of the Patient Transfer notes dated January 25, 2019, lacked the following documented information: "Contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status." The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident #204 to the emergency room on January 25, 2019. A face-to-face interview was conducted on April 25, 2019, at approximately 10:00 AM with Employee#5. The employee acknowledged the finding. 5. The facility staff failed to document the transfer information communicated to the receiving health care institution on Resident #225's medical record. Resident #225 was admitted to the facility on February 4, 2019, with diagnoses to include Anemia, Hyperlipidemia, Osteoporosis, Anxiety Disorder, Depression, and Schizophrenia.	F 622		

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F 622	Continued From page 16 A review of the Admission Minimum Data Set [MDS] dated February 11, 2019. Section C [Cognition Patterns] Brief Interview for Mental Status [BIMS] was recorded as "15" which indicates resident is cognitively intact. A review of the physicians's order dated March 25, 2019 showed, "Resident transfer to [name of facility]." A review of the progress notes dated March 20, 2019 showed a lack of the following documented information: contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident's diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status. The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical records' lack of documentation to show that the information was sent with Resident #225 to the receiving facility on March 25, 2019. Employee #2 acknowledged the finding during a face-to-face interview conducted on April 25, 2019, at approximately 10:00 AM. 6. The facility staff failed to document the transfer	F 622		

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F 622	Continued From page 17 information communicated to the receiving health care institution in Resident #474's medical record. Resident #474 was admitted to the facility on 1/13/17 with diagnoses which include Encephalopathy, Unspecified, Essential (Primary) Hypertension, End Stage on Renal Dialysis, Pressure Ulcer of Sacral Region (Unspecified Stage), Unspecified Dementia without Behavioral Disturbance. Review of the medical record on 4/24/19 at 11:00 AM showed a Comprehensive Minimum Data Set (MDS) dated 3/12/19. Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "11" which indicates moderate cognitive impairment. Review of the physician's order dated 3/26/19 "Transfer resident to the nearest emergency room (ER) via 911." Further review of the progress note dated 3/26/19 showed "resident transferred to [hospital name] and left message for responsible party to call back." Review of the resident's medical record failed to show information given to the receiving health care institution to include the following: contact information of the practitioner responsible for the care of the resident, resident representative including contact information, advance directive information, special instructions, and comprehensive goals. Facility staff failed to provide evidence that all pertinent information (contact information of the practitioner, advance directive information, special instructions and comprehensive goals) was communicated to the receiving facility.	F 622		

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F 622	Continued From page 18 During a face-to-face interview on 4/24/19 at 11:00 AM Employee #3 acknowledged the finding. .	F 622		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of four (4) of 63 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) Resident's diagnosis of Hypomagnesium, to reflect one (1) resident's bladder status, for one (1) Resident's use of pressure reducing device for bed, and for one (1) resident diagnoses of Hyperkalemia/CVA [Cerebrovascular Disease]. Residents' #107,#173, #204, and #210 Findings included... 1. Facility staff failed to accurately code the MDS for Resident 107's diagnosis of Hypomagnesium. Resident #107 was admitted to the facility on January 23, 2019, with diagnoses which include Dysphagia, Oropharyngeal Phase, Scoliosis, Anemia, Hypomagnesemia, Encephalopathy,	F 641	**F-641** **Corrective action for the residents affected:** 1. The MDS coding errors / 0missions for residents #107, #173, #204, #210 were corrected and MDS staff has accurately coded the MDS to reflect the resident status. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. The facility will audit all current residents MDS for accurate coding that reflects the residents status. Any omitted areas identified will be corrected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service with the MDS Coordinators on accurately coding the resident's diagnosis/status. MDS coordinators will conduct weekly audits X4, monthly X3. Audit findings will be forwarded to the DON. **Monitoring corrective action:** 4. Monitoring for accuracy and completions will be added for review during the daily stand-up meetings. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 6/10/19 ongoing

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F 641	Continued From page 19 Hypertension, Generalized muscle weakness, Osteoporosis, and Pneumonia. A review of the Admission MDS dated January 30, 2019, showed that section I Active Diagnoses under I8000 Additional Active diagnoses Hypomagnesemia was not coded. The evidence showed that the facility staff failed to accurately code the MDS to reflect the resident's status. A face-to-face interview was conducted on April 26, 2019, at approximately 12:00 PM with Employee #16. The employee acknowledged the findings. 2. Resident #173 was admitted on November 14, 2016, with diagnoses to include Paraplegia, Neurogenic Bladder, Depression, Diabetes Mellitus, and Hypertension. Review of the comprehensive Minimum Data Set (MDS) dated November 13, 2018 Section C [Cognitive Patterns] indicated Resident #90 was cognitively intact with Brief Interview for Mental Status (BIMS) Summary Score of 15. Section H- [Bladder and Bowel] appliances indwelling catheter and external catheters were both checked. A review of Physicians orders dated April 22, 2018, revealed "External (condom) catheter daily and as needed". During a face- to- face interview with Resident # 90 on April 22, 2019 at 11:00 AM when asked he	F 641		

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F 641	Continued From page 20 stated he does change his catheter daily and as needed without assistance to treat his neurogenic bladder and he has never had an internal catheter. There was no evidence the MDS section H was coded correctly. During a face- to- face interview on April 22, 2019 at 3:00 PM. Employee # 16 acknowledged indwelling catheter was checked in error and that resident has never had an internal catheter. 3. Facility staff failed to accurately code the MDS for Resident #204's diagnosis of Hyperkalemia and Cerebrovascular Disease. Resident #204 was admitted to the facility on June 19, 2018, with diagnoses that included Hyperkalemia, Diabetes Mellitus, Hypertension, Parkinson's Disease, Dysarthria and Anarthria, Cerebrovascular Disease, Chronic Kidney Disease, Generalized Muscle Weakness, Disorientation and Dementia with Behavioral Disturbances. A review of the Significant Change MDS dated March 26, 2019, showed that section I Active Diagnoses under I3200 Hyperkalemia and I8000 [Additional active diagnoses] Cerebrovascular Disease was not coded. The evidence showed that the facility staff failed to accurately code the MDS to reflect the resident's status. A face-to-face interview was conducted on April 26, 2019, at approximately 12:00 PM with Employee #16. The employee acknowledged the	F 641		

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F 641	Continued From page 21 findings. 4. Facility staff failed to accurately code the MDS for Resident #210's use of pressure reducing device for bed. Resident #210 was admitted to the facility on March 7, 2019, with diagnoses that included Hyperkalemia, Diabetes Mellitus, Hypertension, Parkinson's Disease, Dysarthria and Anarthria, Cerebrovascular Disease, Chronic Kidney Disease, Generalized muscle weakness, Disorientation and Dementia with Behavioral Disturbances. A review of the Admission MDS dated April 1, 2019, showed that section M Skin Conditions under M1200 B Pressure reducing device for bed was not coded. The evidence showed that the facility staff failed to accurately code the MDS to reflect the resident's status. A face-to-face interview was conducted on April 26, 2019, at approximately 12:00 PM with Employee #16. The employee acknowledged the findings.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656	**F-656** **Corrective action for the residents affected:** 1. The resident #74 was reassessed on 4/30/19. The comprehensive care plan for resident #74 was revised to include goals and approaches for the resident with urinary tract infection.	4/29/19

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F 656	Continued From page 22 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 63 sampled residents, facility staff failed to develop and implement a comprehensive care plan for Urinary Tract Infection. Resident	F 656	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records for current residents with urinary tract infections was completed by the clinical managers to ensure a corresponding care plan concerning goals and approaches is included. No other resident was affected. **Measures to prevent reoccurrence:** 3. The Staff Development Director will in-service the IDT team to ensure care plans is person centered with goals and interventions to address the resident's diagnosis/status. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Audits of care plan updates will be completed to ensure compliance until three consecutive months of greater than or equal to 95 % compliance has been achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee by the DON monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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F 656	Continued From page 23 #74 Findings included . . . Resident #74 was readmitted to the facility on February 2, 2019, with diagnoses which include Anemia, Hypertension, Diabetes Mellitus, Atrioventricular Block, complete, Malignant Neoplasm of Bladder, Atrial Fibrillation, Generalized Muscle Weakness, Urinary Tract Infection and Dementia without Behavioral Disturbance. . A review of the Admission Minimum Data Set [MDS] dated February 9, 2019. Section C0500 [BIMS (Brief Interview for Mental Status) Summary Score] of "11" moderately impaired cognition which indicates, "Resident never/rarely made decisions". Under Section I2300 Active Diagnoses coded Urinary Tract Infection (UTI) (last 30 days). A review of the nurse's progress notes dated February 3. 2019, showed, "Had UTI, Cephalexin 500mg BID from Hospital with 2 days of Antibiotic" and nurses's progress note dated February 5, 2019, showed "Completed antibiotic." A review of the care plans on the clinical record failed to address care with person-centered goals and interventions to address the resident's Urinary Tract Infection. A face-to-face interview was conducted with Employee #5 at approximately 2:00 PM on April 18, 2019. The employee acknowledged the	F 656		

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F 656	Continued From page 24 findings.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for four (4) of 63 sampled residents, facility staff failed to revise/update care plan for one (1) resident with a suprapubic catheter , (1) resident's use of glasses, one (1) residents use	F 657	**I. F-657** **Corrective action for the residents affected:** 1. The resident #44 was reassessed on 4/30/19. The care plan of resident #44 was revised and updated to include goals and approaches for the resident with catheter size (20 French) and the solution Renacidin used to irrigate the catheter. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all the residents with Suprapubic catheter with the solution Renacidin used to irrigate the catheter were audited. No other resident was affected. **Measures to prevent reoccurrence:** **3.** Staff Development Director will in-service licensed nurses on care plan with goals and approaches for resident that uses Suprapubic catheter. Care plans of residents with Suprapubic catheter and the solution Renacidin used to irrigate the catheter will be audited weekly X4, monthly X3 by the unit. Audit findings will be forwarded to DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 4/30/19 6/10/19 ongoing

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	095036	A. BUILDING _____ B. WING _____	04/29/2019

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F 657	Continued From page 25 of condom catheters and for (1) resident receiving dialysis services. Residents' #44, #89, #90 and #161. Findings included... 1. Resident # 44 was admitted to the facility on 4/24/01 with diagnoses to include Retention of Urine, Benign Neoplasm of Prostate, Unspecified, Muscle Weakness, Major Depressive Disorder, Hypotension, Unspecified, Secondary Parkinsonism and Dementia without Behavioral Disturbance. Review of the Comprehensive Minimum Data Set [MDS] dated 7/19/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "2" which indicates severe cognitive impairment. Review of the nursing care plan dated 7/27/18, showed "Focus: Resident has Suprapubic Catheter for Urinary Retention; Interventions: Change catheter monthly with urologist at [hospital name] ..." Further review of a care plan dated 11/8/18 showed "Focus: "Potential for Urinary Tract Infection related to Urinary Retention and use of suprapubic catheter; Interventions: catheter irrigation done as ordered ..." Review of the physician order dated 3/21/19 showed "Suprapubic catheter 20 French/10 cc/ check leg bag band every shift." Review of the physician order dated 4/20/19	F 657	**II. F-657** **Corrective action for the residents affected:** 1. The resident #89 was reassessed on 4/30/19. The care plan of resident #89 was revised and updated to include goals and approaches for the resident #89 use of eye glasses. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all the residents' use of eye glasses were audited if a corresponding care plan is included for the resident use of eye glasses. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service the IDT team on care plan with goals and approaches for resident that uses eye glasses. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months. **III. F-567** **Corrective action for the residents affected:** 1. The resident #90 was reassessed on 4/30/19. The care plan for resident #90 was revised and updated to include goals and approaches for the resident with the daily use of Condom catheters.	4/30/19 4/30/19 6/10/19 ongoing 4/30/19

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F 657	Continued From page 26 "Renacidin irrigation daily for catheter irrigation 30 cc" Facility staff failed to update the care plan to include the catheter size (20 French) and the solution Renacidin used to irrigate the catheter. During a face-to-face interview on 4/24/19 at 2:00 PM, Employee# 3 acknowledged the findings. 2. Resident # 89 was admitted to the facility on 5/14/18 with diagnoses to include Muscle Weakness, Pain in Left Knee, Abnormalities of Gait and Mobility. Review of the Comprehensive Minimum Data Set [MDS] dated 2/10/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "12" which indicates cognitively intact. Section B [Vision] resident is coded as adequate, able to see fine detail such as regular print in newspapers/books and coded as "no" for corrective lenses. During a resident interview on 4/24/19 at 10:00 AM, in response to the question: Are you having problems with your vision or hearing, resident replied I have cataracts and my vision is blurry my glasses don't help, so I don't wear them. Review of Report of Consultation dated 8/25/18, Findings: "Blurred Vision, Cataract, moderate Cataract OS (left eye) and axial cataract OD (right eye), Recommendations: Glasses, advised to consider cataract surgery right eye if not happy with vision through his glasses." Review of the care plan dated 2/6/19 showed "Focus: the resident has impaired visual function	F 657	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records for current residents with the daily use of Condom catheters was completed by the clinical manager to ensure a corresponding care plans concerning goals and approaches is included. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will educate nursing staff on care plan updates as they relate to resident with Condom catheters. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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F 657	Continued From page 27 related to Cataracts and blurred vision. Interventions: Arrange consultation with eye care practitioner as required, monitor and document/report s/s of acute eye problems. During an interview on 4/24/19 at 11:30 AM, Employee #3, stated "I did not know he wears glasses and I found them in his drawer in his room the glasses are right here (Employee #3 was a holding an eyeglass case with a clear cover labeled with the resident's name), I will call the doctor to schedule an eye appointment." Facility staff failed to revise/update care plan with goals and approaches for Resident #89 use of eye glasses. During a face-to-face interview on 4/24/19 at 1:00 PM, Employee# 2 acknowledged the findings. 3. Resident #90 was admitted on November 14, 2016, with diagnoses to include Paraplegia, Neurogenic bladder Depression, Diabetes Mellitus, and Hypertension. Review of the admission Minimum Data Set (MDS) dated November 13, 2018 showed Resident #90 was cognitively intact with Brief Interview for Mental Status (BIMS) Summary Score of 15. A review of Physicians orders dated April 22, 2019 revealed "Condom Catheter daily and as needed".	F 657	**IV. F-567** **Corrective action for the residents affected:** 1. The resident #161 was reassessed on 4/30/19. The care plan for resident #161 was revised and updated to include goals and approaches for the resident to show collaboration with the certified dialysis center. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records for current residents going to certified Dialysis center was completed by the clinical managers to ensure corresponding care plans concerning goals and approaches is included. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service the licensed nursing staff on care plan updates as they relate to residents on Dialysis and collaborating with the certified Dialysis Center regarding residents care. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 4/30/19 6/10/19 ongoing

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F 657	Continued From page 28 During a face- to- face interview on April 22, 2019 at 11:30 AM, Resident # 90, stated he does change his catheter daily and as needed without assistance to treat his neurogenic bladder. There was no evidence the facility updated the care plan with goals and approaches to reflect the daily use of condom catheters. Employee # 7 acknowledged the findings during a face- to- face interview on April 22, 2019 at 12:00 PM. 4. Resident #161 was admitted to the facility on 11/12/14 with diagnoses to include Dependence on Renal Dialysis, Hypothyroidism, Hyperlipidemia, Essential (Primary Hypertension), Dysphagia. Review of the Quarterly Minimum Data Set [MDS] dated 2/19/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "15" which indicates cognitively intact. Section O [Special Treatments and Programs] showed dialysis is selected to indicate resident receives dialysis. Review of the care plan initiated on 8/7/18 with a revision date of 3/11/19, Focus: Resident needs dialysis related to renal failure and dialysis days are Tuesday, Thursday and Saturday; Interventions: Dialysis kit at the bedside, do not draw blood or take blood pressure in arm with graft, encourage resident to go for scheduled dialysis appointments. During an interview on 4/24/19 at 2:00 PM, Employee #4, states "we have a book that we send to dialysis and the nurses write down	F 657		

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F 657	Continued From page 29 everything, we did not communicate with the dialysis center to write his care plan." Review of the care plan failed to show collaboration with the certified dialysis center to develop goals and approaches specific to the needs of a resident on dialysis. Facility staff failed to revise/update resident's care plan in collaboration with the dialysis center. During a face-to-face interview on 4/24/19 at 2:00 PM, Employee #4 acknowledged the findings.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Medpass observation and interview for one (1) of 63 sampled residents, the facility staff failed to provide care in accordance with professional nursing standards as evidenced by the staff was observed using her personal blood pressure machines incorrectly to measure one (1) resident's blood pressure. Resident #39. Findings included... According to the American Heart Association: "Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure-related risk, and to guide management.	F 658	**F-658** **Corrective action for the residents affected:** 1. The resident #39 was reassessed on 4/30/19. Resident #39 has no negative outcome. Employee #10 was immediately counseled regarding the use of his/her personal blood pressure machines incorrectly to measure resident #39 blood pressure. **Identification of others with potential to be affected:** **2.** All residents have the potential to be affected. No other resident was affected by this deficient practice as evidenced by medication pass observation by the unit managers. Any identified issues were corrected. **Measures to prevent reoccurrence:** 3. Licensed staff will be in-serviced on obtaining blood pressure using professional machine and staff competencies will be developed to ensure blood pressure taking in accordance with professional standards by the Staff Development Director. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON.	4/30/19 4/30/19 6/10/19