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	HFD02-0010	A. BUILDING: ______ B. WING ______	04/29/2019

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

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L 000	Initial Comments	L 000	UNIQUE REHABILITATION & HEALTH CENTER DISCLAIMER	

Initial Comments

The unannounced Annual Licensure 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 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
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)

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.

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L 000	Continued From page 1 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 TX- Treatment	L 000		
L 005	3201.4 Nursing Facilities If the Administrator is absent for more than six (6) consecutive weeks the facility shall designate an acting administrator who is qualified to be an administrator and shall notify the licensing	L 005		

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L 005	Continued From page 2 agency. This Statute is not met as evidenced by: Based on medical record review and staff interview for four (4) of 63 sampled residents, the charge nurse failed to revise/update care plan for one (1) resident with a suprapubic catheter , (1) resident's use of glasses, one (1) residents use 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 a Comprehensive Minimum Data Set dated 3/20/19. 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	L 005	**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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L 005	Continued From page 3 ..." 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 "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 a Comprehensive Minimum Data Set dated 3/20/19. 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	L 005	**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.	4/30/19 4/30/19 6/10/19 ongoing

Health Regulation & Licensing Administration

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L 005	Continued From page 4	L 005		
	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."		**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
	Review of the care plan dated 2/6/19 showed "Focus: the resident has impaired visual function 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.		**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.	4/30/19
	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."		**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.	6/10/19
	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.		**Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	ongoing
	3. Resident #90 was admitted on November 14, 2016. 10, 2015, 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.			

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L 005	Continued From page 5 A review of Physicians orders dated April 22, 2019 revealed "Condom Catheter daily and as needed". 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 a Comprehensive Minimum Data Set [MDS], 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.	L 005	**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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L 005	Continued From page 6 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 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	L 005		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on record review and staff interview for 63 sampled residents, the facility failed to conduct infection surveillance to identify, track, monitor and/or report infections for five (5) of 12 months during 2018. Findings included . . . According to the Center for Disease Control's (CDC's) definition "Surveillance is defined as the	L 091	**Corrective action for the residents affected:** **1.** There was no negative outcome for this deficiency practice. The facility could not retroactively correct the deficiency. The facility re-initiated the infection surveillance program. A Director of Quality Assurance was hired. The QA Director is responsible to conduct infection surveillance to identify, track, monitor and/or report infections. **Identification of others with potential to be affected:** **2.** All residents have the potential to be affected. The Infection Surveillance Program was reviewed by the Administrator and the DON to determine adequacy and effectiveness. Infection Surveillance Program has been developed and are being tracked to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff, volunteers, visitors, and other individuals.	4/29/19 4/29/19

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L 091	Continued From page 7 ongoing systematic collection, analysis, interpretation and dissemination of data." National Healthcare Safety Network (NHSN) Overview, Options for Long-term Care Facilities January, 2019. Facility failed to provide evidence that infection surveillance was conducted for 5 months; July, August, October, November and December of 2018. On April 29, 2019 at approximately 2:47 PM a review of the facility's Infection Control Program was conducted with Employee #2. During the interview the employee failed to present a line listing of any residents who were admitted into the facility with infections that were community acquired; residents who acquired infections while in the facility; any illnesses that required residents to be isolated; residents who required treatment with antibiotics and/or other contagious diseases for the months of July, August, October, November and December 2018. When asked about the absence of the reports the employee was not able to present them and acknowledged that no data was collected for those 5 months. The facility failed to conduct infection surveillance to identify, track, monitor and/or report infections for five (5) of 12 months during 2018.	L 091	**Measures to prevent reoccurrence:** 3. Staff Development Director will in-service license nursing staff on Infection Surveillance Program, developing, tracking to ensure a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff, volunteers, visitors, and other individuals. Auditing the medical record will be reviewed during daily stand-up meetings and during quarterly QA meetings. Weekly audits will be performed for 3 months. Findings will be forwarded 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.	6/10/19 ongoing

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L 091	Continued From page 8 Employee #2 acknowledged the finding during a face-to-face interview on April 29, 2019 at approximately 2:47 PM.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain food equipment in safe condition as evidenced by four (4) of eight (8) hood baffles that were soiled with grease, three (3) of nine (9) one-quarter full pans and two (2) of 22 sheet pans that were stored wet, a leak from the ceiling area in front of the walk-in freezer, inadequate monitoring of freezer temperatures and food items that were not totally frozen in one (1) of one (1) walk-in freezer. Findings included ... The following observations were made during a walkthrough of dietary services on April 17, 2019, thru April 23, 2019. 1. Four (4) of eight (8) hood baffles were soiled with grease residue. 2. Three (3) of nine (9) one-quarter full pans and two (2) of 22 sheet pans were stored wet on a ready-for-use shelf. 3. A clear fluid was dripping slowly and steadily from the ceiling area located in front of the	L 099	**F-812** **Corrective action for the residents affected:** 1. The hood baffles that were soiled with grease was cleaned immediately after being identified during the survey. • One-quarter full pans and sheet pans that were stored wet was immediately cleaned after being identified during the survey. • Raw foods that were inappropriately thawed in the walk-in freezer has been thrown away immediately after being identified during the survey. The improper food monitoring of food temperatures in the walk-in freezer has been corrected. • The freezer and walk-in boxes were serviced. • New Fahrenheit digital thermostats were installed on each of the walk-in boxes. • New temperatures logs were created for dietary staff for all the walk-in boxes and freezer box. • The staff were in-serviced to not prop any of the doors to the freezer or walk-in boxes open. • The dietary staff were also advised to pack the boxes in such a way to not impede the air flow from the evaporator fan. • The leak on the recirculating hot water line above the freezer door was contained.	4/29/19

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L 099	Continued From page 9 walk-in freezer. 4. Record review of the facility's policy titled, "Food Temperatures," dated 01/19, showed that refrigerators and freezer temperatures are to be monitored twice a day at opening and closing. A review of the freezer truck temperature log on April 26, 2019, at approximately 8:45 AM showed that internal freezer truck temperatures were documented just once on April 23, April 24 and April 25, 2019. 5. On April 17, 2019, at 2:17 PM, temperature gauges (2) located on the inside of the walk-in freezer read 28 degrees Fahrenheit (F) and 31 degrees F. The temperature gauge located outside the walk-in freezer read 22 degrees F. This surveyor's thermometer read 30.9 degrees F. Food items such as sausage patties and muffins were soft to the touch, but two (2) of two (2) pieces of fish were frozen solid. Four (4) of four (4) large chunks of top round beef were mostly frozen throughout except at the top which was soft to the touch. On April 17, 2019, at 5:18 PM, Employee #18 from this facility's maintenance department completed a work order submitted on April 17, 2019, at 2:49 PM with an entry stating "The refrigerator thermostat is working properly, the staff are leaving does (door) open	L 099	**Identification of others with potential to be affected:** 2. A review was conducted by the Engineering Director and Dietary manager no other components of the kitchen equipment was impacted by this practice. A review of the walk-in freezer temperatures and all other identified issues was conducted by the Dietary manager and no other issues were identified or impacted by this practice. **Measures to prevent reoccurrence:** 3. The Dietary manager will educate the dietary staff on appropriate and required holding temperature and monitoring the sanitary condition of the kitchen. The Dietary manager will review, develop and implement training to address how to place a work-order and maintain safety and sanitary condition of the kitchen. Dietary supervisor will conduct a weekly audit X4, monthly X3. Audit findings will be given to the Dietary Manager. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/29/19 6/10/19 ongoing

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L 099	Continued From page 10 for a long time so the temperature drops that way". On April 18, 2019, at 10:03 AM, the internal temperatures of the walk-in freezer read 32 degrees F and 34 degrees F from both gauges. At the time of observation, the door to the walk-in freezer was held open by staff to store recently delivered food items. At approximately 10:12 AM, the internal temperature of the walk-in freezer was 34.8 degrees F as measured from this surveyor's thermometer but food items such as a box of chicken nuggets and four (4) of four (4) twenty-ounce bags of French fries were frozen solid. At approximately 2:30 PM on April 18, 2019, the maintenance representative from Tidewater Refrigeration informed this surveyor that he did not identify any technical issues with the walk-in freezer and the temperatures normally increase during any and all of the freezer's four (4) defrost cycles. On April 19, 2019, at approximately 9:10 AM, Employee #11 presented a copy of a sign-in sheet for an in-service that was done for dietary staff in regards to keeping the refrigerator and freezer door close to maintain internal temperatures. At 4:15 PM on April 19, 2019, the outside temperature gauge of the walk-in freezer read 28 degrees F.	L 099		

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On April 22, 2019, at 7:13 AM and at 7:38 AM, Employee #19 from this facility's maintenance department completed a work order submitted on April 20, 2019, with an entry stating "The outside thermometer was checked and it is reading the inside temperature accurately." and "No problem with thermometer".

On April 22, 2019, at 9:22 AM, the temperature of the walk-in freezer was 36 degrees F.

At about that time, Employee #11 informed this surveyor that the facility had rented a freezer truck on Sunday, April 21, 2019, and staff had moved all foods from the walk-in freezer to the freezer truck after it was delivered.

Employee #11 was asked for a written statement to describe the events on April 19, 20th. and 21st. that led to the decision by the facility to rent a freezer truck. Employee #11 presented this surveyor with a copy of an e-mail from employee #17, a consultant for the facility.

According to the e-mail, Employee #17 came in to the facility on the evening of April 19th to "address temperature issues relating to the walk-in freezer" and placed a service call with Tidewater Refrigeration. "In addition the meats were placed in another cooler." The facility has a small freezer available in the kitchen.

"Tidewater came out at 11:00PM on April 19th and determined that the walk in box needed a TXV (Thermostatic

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	HFD02-0010	A. BUILDING: ______ B. WING ______	04/29/2019

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expansion valve) valve. They came back at Saturday April 20th @ 8:00am and finish the repair At 1.00 PM
Saturday April 16th [sic] (20th). Tidewater called me and assured that the freezer unit was working properly at that
time. I stop by the site on Sunday at 8:00am and found the temps in the cooler at 21 degrees. At that point I called
Tidewater Refrigeration back and they came back at 1:00PM. On Sunday morning April 21st it was decided to
invest in a refrigerated freezer truck. The truck was delivered at 3:00PM on April 21st to the site."

A copy of an e-mail from Tidewater Refrigeration to the facility, dated April 22, 2019 states:

"The walk-in freezer at your location was running normally when the tech arrived. Unit at 7 degrees. This unit is
made to store product that comes in frozen or from freezer to freezer. (The frozen product from another freezer
into the WI freezer. The product is already frozen & will stay that way). It is not made to freeze product from the
cooler to freezer instantly or with-in a short time frame. It will take considerable time to freeze that product."

On April 22, 2019, at 11:12 AM, the temperature inside the freezer truck was 12.5 degrees F and all foods were
frozen solid.

The outside temperature of the empty walk-in freezer was monitored throughout the survey. On April 22, 2019, at

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approximately 11:30 AM, Employee #11 placed two (2) buckets of water inside the empty walk-in freeer as a way to test its freezing capability. The freezer was locked to prevent facility staff from opening the door and therefore causing temperatures to fluctuate.

The following are walk-in freezer temperature readings from the temperature gauge located outside the walk-in freezer throughout the survey:

Date	Time	Temperature
4-23-2019	8:50 AM	17 degrees F
4-23-2019	4:37 PM	-16 degrees F
4-24-2019	8:59 AM	16 degrees F
4-24-2019	4:21 PM	-20 degrees F
4-25-2019	9:08 AM	20 degrees F
4-25-2019	9:17 AM	4 degrees F
4-25-2019	4:35 PM	-20 degrees F
4-26-2019	8:33 AM	-20 degrees F
4-26-2019	10:24 AM	-10 degrees F
4-26-2019	2:30 PM	-20 degrees F
4-29-2019	9:00 AM	0 degrees F
4-29-2019	5:32 PM	-21 degrees F

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L 099	Continued From page 14 On April 25, 2019, at approximately 4:35 PM, this surveyor requested Employee #12 to unlock the walk-in freezer. Inside, the two (2) buckets of water that had been placed on a shelf since Monday, April 22, 2019, by Employee #11 were frozen solid. The internal gauges read -20 degrees F and -17 degrees F. Frozen foods remained in the freezer truck where temperatures were stable and food items were frozen solid. During a face-to-face interview on April 25, 2019, at approximately 11:00 AM, Employee #11 acknowledged these findings.	L 099		
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on observation, medical record review and staff interview for two (2) of 63 sampled residents, facility staff failed to accurately document one resident's use of psychotropic medications on four (4) of five (5) fall assessment forms; and failed to maintain facility documents (shower sheets) that were accurate and complete to ensure medical records are maintained in a systematically organized manner. Residents #29 and #111. Findings included . . . Record review of the facility's policy titled Mobility	L 190	**Corrective action for the residents affected:** 1. Resident # 29 MDS was corrected to reflect the use of psychotropic medication. Resident #111 missing shower sheets could not be retroactively corrected. The involved employee will be counseled for failure to accurately document the use of Psychotropic medications, fall assessment forms and failed to maintain facility shower sheets. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. The facility has audited all resident on Psychotropic medications, fall assessments forms and shower sheets. Correction made as applicable.	4/29/19 4/29/19

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L 190	Continued From page 15 and Falls/Falls with Injury Prevention with a revised date of February, 2019, "Fall risk assessment is done upon admission and readmission and quarterly." 1. Resident #29 was admitted to the facility on April 21, 2016 with diagnoses which included Hypertension, Hyperlipidemia, Non-Alzheimer's Disease, Generalized Muscle Weakness and Paranoid Personality Disorder. According to the quarterly Minimum Data Set (MDS) which was completed on January 13, 2019 the resident's Brief Interview for Mental Status (BIMS) score was four (4) which indicates that the resident is significantly cognitively impaired. In section G0110 Activities of Daily Living (ADL) Assistance the resident is coded as requiring supervision and support from staff for the following activities, (Bed mobility, Transfer, Locomotion on unit, Personal Hygiene, Toileting, Dressing and Eating). In section G0120 Bathing the resident needs physical help and support in part of bathing activity. During a face-to-face interview with Employee #2 at approximately 3:00 PM on April 26, 2019 the employee informed this writer that, "Fall Assessments are done on admission, readmission, quarterly and after every fall". Review of the current Physician's order sheet for the month of April showed that Resident #29 was initially placed on Quetiapine (Seroquel)12.5 mg (milligrams) Q (every) 12 hours for Dementia with Psychosis on October 12, 2017. A nurse's progress note dated April 4, 2019 showed that Seroquel was decreased to 12.5mg daily after the	L 190	**Measures to prevent reoccurrence:** 3. Staff Development Director will in-serve licensed nursing staff and MDS coordinators on accurately documenting the use of Psychotropic medications, fall assessment forms, and shower sheets. 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.	6/10/19 ongoing

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resident sustained a fall without injury at approximately 2:00 AM on April 4, 2019
Five (5) Fall Risk assessment forms were reviewed. Each form is divided into 11 categories:

1. Reason for Assessment Request
2. Date of Admission
3. History of Falls within last six months
4. Medication Use: Medication taken more than 3x/week including prn's
5. Memory and recall ability
6. Vision Pattern
7. Continence in last 14 days
8. Agitated Behavior
9. Confined to a chair
10. Blood Pressure: Drop in Systolic pressure
11. Gait Analysis: Assess resident's gait while standing in one spot, walking straight forward and while making a turn.

Under item 4 Medication Use, 12 classes of medications are identified and Psychotropic medication is included among the medications. However, the facility staff failed to check this class of medication (Psychotropic) although the resident received Seroquel daily from October 12, 2017 to present (April 29, 2019.)

The Fall Risk Assessment Forms that were not checked for the use of Psychotropic medications were dated July 20, 2018, December 30, 2018, January 20, 2019 and February 20,2019.

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A face-to-face interview was conducted with Employee #2 at approximately 10:00 AM on April 29, 2019. During the interview Employee #2 acknowledged the finding that the facility staff failed to document the use of Psychotropic medications on the Risk Assessment Forms.

2. Resident# 111 was admitted to the facility on 2/22/19 with diagnoses to include: Essential (Hemorrhagic) Thrombocythemia, Unspecified Wound, Left Knee, and Essential (Primary) Hypertension.

Review of the Comprehensive Minimum Data Set [MDS] dated 3/1/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "13" which indicates cognitively intact.

During a patient interview on 4/24/19 at 11:00 AM resident stated "I have a concern about my roommate he refuses showers and he has a bad odor he wears a diaper and he has to wait for staff to change him, I told the social worker that I want my room changed."

During an interview on 4/24/19 at 11:30 AM, Employee #21 states "The resident did come to me but he did not tell me what he wanted to talk to me about, I will go back to him and see if I can address his concern."

Observation on 4/24/19 at 12:00 PM showed Resident # 197 (roommate of Resident # 111), sitting quietly in a wheelchair in his room, there was no odor detected and his clothing did not appear to be soiled.

Resident #197 was admitted to the facility on

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10/25/2005, with diagnoses to include; Hypertension, Pneumonia, Hyperlipidemia, Aphasia, Non-Alzheimer's Dementia and Hemiplegia.

Review of the Comprehensive Minimum Data Set [MDS] dated 3/1/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "6" which indicates severe cognitive impairment. Section G [Functional Status] resident was coded as "4" for bathing which indicate total dependence (full staff performance every time).

Review of the facility documents (shower sheets) for the month of March showed "Resident #197, shower days Tuesday and Friday" and the sheets were left blank with the exception of three days "refused" was written without a date or signature.

Review of April shower sheets showed "Resident #197 shower days Tuesday and Friday" the sheets were blank.

During an interview on 4/24/19 at 1:00 PM Employee #2 states "I see the sheets are blank and you can't tell if the resident received a shower or not I will talk with the staff about completing and signing the sheets"

Facility staff failed to maintain facility documents (shower sheets) for accuracy and completeness to indicate whether a resident received a shower on scheduled shower days.

During a face-to-face interview on 4/24/19 at 1:00 PM, Employee #2 acknowledged the findings.

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L 201	Continued From page 19	L 201		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe	L 201		