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	095022	A. BUILDING _____ B. WING _____	02/20/2020

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TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45 During a face-to-face on 2/18/20 at 12:24 PM, Employee #9, Unit Manager, acknowledged the finding. Employee #9 then stated " Resident has consistent falls. He is non-adherent to the education staff gives him. We ask him to call for help, but he still tries to walk and transfer by himself." The facility's staff failed to provide supervision for Resident #305. (3). The facility's staff failed to supervise Resident #187 and Resident #226 after placing them in a ride share car (Uber). A. Review of Resident #187's medical record showed that she was admitted to the facility on 09/16/19 with several diagnoses including Hypertension and End-Stage Renal Disease. Review of the Admission Minimum Data Set (MDS) dated 09/23/19, showed Section C (Cognition Patterns) C1000 Cognitive Skills for daily decision making was scored as "15" which indicated that the resident was cognitively intact. Under Section G0300 the resident was coded as not steady, but able to stabilize without human assistance, and requires supervision with transfers, locomotion off the unit with one person physical assistance. During a face-to-face interview with Resident #187, on 02/10/20 at approximately 11:00 AM, she stated, "I went out with another resident, far out in Maryland to look at an Assisted Living Facility about 3-4 weeks ago. I only went because I was told that if I didn't pick a place I would be discharged to a shelter." Resident #187	F 689		

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F 689	Continued From page 46 then said, "I chose not to rent a room at the Assisted Living facility because my dialysis center is far from the facility, and I have limited income." B. Review of Resident # 226's medical record showed that he was admitted to the facility on 09/02/2018, with several diagnoses including Cerebral Vascular Accident (CVA), Hypertension and Diabetes Mellitus. Review of the Admission Minimum Data Set (MDS) dated 01/08/20, showed Section C (Cognition Patterns) C1000 Cognitive skills for daily decision making wAS recorded as "13", which indicated that the resident was cognitively intact. Under Section G the resident was coded as requiring supervision to transfers, locomotion off the unit with one person physical assistance, not steady, but able to stabilize without human assistance; Additionally, the resident was coded as having impairment on one side of his upper extremities and using a wheel chair. Through observation on 02/19/20 at 5:35 PM, the resident was observed using a rollator walker to assisst with ambulation. During a face-to-face interview on 02/19/20 at 5:35 PM, Resident #226 explained that on 01/24/20 (Friday), Employee #29, Social Worker, called an Uber to drive him along with another resident (Resident #187) to look at some rooms that were available for rent in Clinton, Maryland, approximately 15 miles away. Continued interview the resident stated, "It felt scary for me to be in a car and have no idea where I was going." The resident then stated that the Uber driver dropped him and other resident	F 689		

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F 689	Continued From page 47 (Resident #187) off in front of a private home where he met a male (the renter) and a female. Further interview with Resident #226, revealed that the home had available rooms for rent upstairs and downstairs (basement). The resident stated, "I was unable to observe the rooms upstairs because I could not go up the steps with my walker and the stairs did not have (hand) rails." Continued interview with Resident #226 revealed that when he made the renter aware he was unable to safely navigate the stairs, the renter told him to "go outside to the back of the house, so that he could access the basement from an outside door." The resident indicated that he refused to go to the back of the house because he was not interested in moving so far away from DC. Resident #226 then said, "I called the nursing home and informed the social worker (Employee #29) that I did not like the room and needed someone to pick us up." During a face to face interview on 02/19/20 at 5:30 PM, Employee #29, Social Worker, acknowledged the finding. Employee #29 then stated " The two residents (Residents #187 and #226) went together in an Uber to Clinton, Maryland. We (the facility) paid for the Uber. It was early in the day." Employee #29 was asked, is this your practice? She replied, "I didn't think this was an issue because the gentlemen that owns the Assisted Living is familiar with us [the facility]". During a face-to-face interview on 02/19/20 at	F 689		

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F 689	Continued From page 48 5:32 PM, Employee #1, Adminstrator, stated "We have a transportation system that has 10 escorts to take residents back and forth to appointments." The facility's staff failed to provide adequate supervision to Residents' #187 and #226 when they sent them without a facility escort to visit an Assisted Living facility in Clinton Maryland, approximately 15 miles away from the nursing home Through interview with one resident he stated, "It felt scary for me to be in a car and have no idea where I was going." and once the resident entered the Assissted Living facility, they did not have hand rails to aid in the resident's safe navigation of the stairs within the home.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690	1. Resident #23's care plan was updated to reflect a toileting schedule to ensure his incontinence care is frequent and consistent enough to avoid his waiting long periods of time for staff to assist him.	

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F 690	Continued From page 49 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to provide incontinent care in a timely manner for one (1) of 75 sampled residents (Resident #23). Findings included... During an interview with Resident #23 on 02/14/20 at 10:00 AM, the resident stated that the dayshift staff did not provide incontinent care for him on 02/12/20 at 2:00 PM when he returned from his doctor's appointment. The resident then said, "I was sitting in my wheelchair, wet all the way down to my feet." Continued interview revealed that staff answered his call light several times but did not provide the care until 4:00 PM when the next shift (evening shift) came to work. When queried, why staff didn't provide incontinent care? Resident #23 stated that he was told his assigned certified	F 690	2. The facility recognizes that all residents have the potential to be affected by this finding. An audit was performed and no residents experienced a negative outcome by this finding. 3. The Interdisciplinary Team Members were in-serviced by Regional Nurse Consultant on the appropriate updating of resident care plans, particularly regarding falls and supervision. Resident care plans will be updated, at a minimum, quarterly, annually, and with change of condition. Incontinence care will be reviewed at these care plan meetings to ensure appropriate interventions are in place. 4. Unit Managers will audit five (5) random residents from each Unit monthly and verify that care plans have been updated and report their findings to the QAPI Committee for further review and recommendation.	4/8/20

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F 690	Continued From page 50 nursing assistant was providing one to one care for another resident. During an interview on 02/14/20 at 11:00 AM, Employee #22, the person who arranges residents' appointments, stated that Resident #23 returned from his appointment on 02/12/20 at 1:45 PM. Review of the Resident # 23's current medical record on 02/14/20 at 2:00 PM showed that the resident was initially admitted on 07/30/19 with several diagnoses including Morbid Obesity and Cerebral Infarct. Continued review of the resident's medical record revealed a Quarterly Minimum Data set (MDS) dated 11/06/19. The MDS data showed the following: Section G0110 (1A) Toilet Use - the resident, was coded as "3" indicating that the resident needed extensive assistance from two (2) staff members with this activity of daily living; Section G0300 (E) Surface to Surface Transfers - the resident was coded as "2", indicating that the resident was not steady and needed staff assistance with stabilizing when transferring from one to surface to another; and Section G0600 (C) Mobility Devices - the resident was coded as "wheelchair," indicating that the resident "normally" used a wheelchair. Further review of Resident # 23's medical record showed a Care Plan with an initiation date of 07/30/19 that revealed a Focus area of Incontinent Bladder with an Intervention that	F 690		

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F 690	Continued From page 51 instructed the staff to "Check [resident's name] every 2 hrs [hours] and as required for incontinence". During an interview on 02/15/20 at 3:00 PM, Employee #2 (DON) and Employee #7 acknowledged the finding. The facility's staff failed to provide Resident #23 with incontinent care, although he asked for help several times on 02/12/20.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 692	1. The nurse was immediately educated on starting tube feeding on time for Resident #148, with the appropriate date and time written on the feeding bag. On 02/11/2020, the resident's tube feeding was started and stopped appropriately and the resident received the total volume of feeding as ordered. Resident #233's G-Tube site was cleansed immediately and gauze replaced. The physician was notified and ordered bacitracin to G-tube site daily. Bacitracin applied to site and new gauze applied with current date and time. 2. An audit of residents with G-Tubes was performed and there were no other issues identified. 3/13/20 3. Nursing staff were in-serviced immediately on the proper procedure 3/5 - 3/15/20	

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F 692	Continued From page 52 interview for one (1) of 75 sampled residents, facility staff failed to administer Resident #148's enteral feeding as directed by the physician. Findings included . . . Review of physician's order showed resident with newly inserted Gastrostomy tube (Inserted 2/7) and enteral feeding with Jevity 1.5 at 40ml/hr. x 18 hours Feeding to be hung at 12:00 PM and to run until 6:00 AM; plus water flushes of 200ml every 6 hours. During an observation of Resident #148's room at 1:20 PM on February 11, 2020 the resident was observed lying in bed on his right side. A pole was on the right side of the bed but no enteral feeding was noted hanging on the pole or in the room. Employee #5 was taken to the room and asked to verify the time that the feeding should be hung. The employee checked the order and acknowledged that the feeding was scheduled to be hung at 12:00 PM one hour and twenty minutes earlier. Employee #5 acknowledged the finding; that the facility staff failed to administer Resident #148's enteral feeding as directed by the physician.	F 692	for managing G-tube feeding and providing standard hygiene and care. 4. Unit Managers will perform audits weekly of G-Tube residents and the care provided and report to the Director of Nursing. The DON shall summarize the results of these audits and report to the QAPI Committee monthly for further review and recommendation.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 693	Continued From page 53 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview for one (1) of 75 sampled residents, the facility's staff failed to provide appropriate care to the Percutaneous Endoscopic Gastrostomy tube (PEG-tube) site for one (1) resident. (Resident #233). Findings included... According to the Nursing Times Journal, "It is vital that nurses are aware of the complications that may arise when caring for a patient with a PEG [percutaneous endoscopic gastronomy] tube	F 693	1. Resident #233's G-Tube site was cleansed immediately and new gauze replaced. The physician was notified and ordered Bacitracin to the G-tube site daily. Bacitracin applied to site and new gauze applied with current date and time. 2. An audit of residents with G-Tubes was performed and there were no other issues identified. 3. Nursing staff were in-serviced immediately on the proper procedure for managing G-tube feeding and providing standard hygiene and care. 4. Unit Managers will perform audits weekly of G-Tube residents and the care provided and report to the Director of Nursing. The DON shall summarize the results of these audits and report to the QAPI Committee monthly for further review and recommendation.	3/13/20 3/5-3/15/20

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F 693	Continued From page 54 (g-tube) ...The most common complication is an infection at and around the insertion site ... Infection can present as inflammation around the site, coupled with discharge and pain or discomfort ... Nurses should follow their local dressing policy for cleaning wounds ... The number of times per day that sites need to be cleaned will depend on the amount of leakage; a dressing may be required to absorb any moisture from the wound." https://www.nursingtimes.net/clinical-archive/nutrition/peg-tubes-dealing-with-complications-31-10-2014/ Review of the facility's policy Enteral Feedings - Safety Precautions Level 111 (revised November 2018), Title: Preventing Skin Breakdown. Instructed the staff to: Keep the skin around the exit site clean, dry, and lubricated (as necessary). Assess for leaking around the gastrostomy .... with each feeding or medication administration ... Observe for signs of skin break down. Observation of Resident #233's PEG-tube site on 02/13/20 at approximately 1:30 PM showed that the insertion site was covered with a white gauze dated and time 02/13/20 6 AM. Further observation of the gauze revealed that the gauze appeared to have a moderate amount of brownish colored drainage. After Employee #8, staff nurse, was queried about the brownish colored drainage on the dressing, he changed the dressing.	F 693		

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F 693	Continued From page 55 A review of the physician order sheet for February 2020 showed an order dated 01/24/20 that directed, "Every night shift cleanse site [G-tube] with soap and water unless otherwise prescribed. If drainage noted, may cover with aviant [avant] drain sponge or similar every night shift for G-tube site care." The evidence showed facility staff failed to ensure Resident#233's G-tube site was examine and cleaned at the insertion site to identify, lessen or resolve possible skin irritation and local infection as evidence by the gauze dressing removed from around the G-tube insertion site was observed to be saturated with brownish drainage. During a face-to-face interview on 02/13.20, at approximately1:35 PM, Employee #8 acknowledged the finding.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility staff failed to ensure that they followed a	F 695	1. The concentrator for Resident #215 was adjusted after confirming the order. Care plan reflects the specific amount of oxygen that the concentrator should be set at. 2. An audit of all concentrators as well as oxygen via nasal cannula was performed facility-wide. No other resident was affected by this finding.	3/20/20

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F 695	Continued From page 56 physician order for oxygen therapy for one (1) of 75 sampled residents (Resident #215). Finding included... Observation on 02/09/20 at 8:00 AM of Resident #215's room showed the resident sitting in bed receiving oxygen at a flow rate of 7 liters per nasal cannula by way of an oxygen concentrator. Review of the resident's current medical record on 02/09/20 at 8:15 AM showed that Resident #215 was admitted on 09/24/19 with several diagnoses including Restrictive Lung Disease, Chronic Obstructive Pulmonary Disease, Sarcoidosis of Lungs, Acute Respiratory Failure, and Dyspnea. Further review of the record revealed a physician order dated 12/26/19 that ordered: "Continuous Oxygen @ (at) 6L (liter) via nasal cannula r/t (related to) history of restrictive lung disease." During a face to face interview at the resident's bedside on 02/09/20 at 8:20 AM, Employee #17 (RN) observed Resident #215's oxygen concentrator and acknowledged the finding. Employee #17(RN) stated that the resident was ordered 6 liters of oxygen and not 7 liters, as set on the concentrator. Employee #17 (RN) then decreased the oxygen flow rate from 7 liters to 6 liters. The facility's staff failed to ensure Resident #215 received oxygen therapy as ordered.	F 695	3. Licensed nursing staff was in-serviced on the proper settings of oxygen concentrators and returned demonstrations to verify competency. 4. Unit Managers will randomly audit 5 residents weekly to inspect and ensure that oxygen concentrator settings are correct based on physician orders. Any findings will be corrected immediately, staff directed to the educator for re-training, and a summary submitted to the QAPI committee monthly for review and further recommendation(s).	3/3/20-3/20/20
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

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F 698	Continued From page 57 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 75 sampled residents, facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility and dialysis staff was included in the medical record for Resident #322. Findings included... Facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility staff and dialysis staff was included in Resident #322's medical record. Resident #322 was admitted to the facility on 9/27/18, with diagnoses to include Hypotension, Hyperlipidemia, End-stage renal disease, Dementia, Diabetes Mellitus, Major Depression, and Cataract. Review of Resident #322's medical records from 1/25/20 to 2/3/20, showed that the resident goes to Dialysis on Tuesdays, Thursdays, and Saturdays. The resident's dialysis record for communication between the dialysis center and the facility was not included as part of the resident's medical record.	F 698	1. Resident #322's dialysis record was placed on her chart immediately. There was no negative outcome associated with this finding. 2. An audit of residents receiving dialysis services was performed to ensure that the dialysis records were in resident charts. 3. Unit secretaries and nurses were in-serviced to ensure that they maintain resident dialysis records routinely. 4. The Unit secretaries will audit dialysis records weekly and report to the Unit Managers. The Unit Managers will summarize the results of these audits and submit their findings to the DON who shall report to the QAPI Committee monthly for further review and recommendations.	3/6-3/13/20 3/14/20

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F 698	Continued From page 58 Observation made on 2/13/20, at approximately 4:14 PM of the resident's dialysis communication record and the medical record showed that they were maintained in a separate binder and not as a part of the resident's active clinical record. A face-to-face interview was conducted with Employee #8 on 2/13/20, at approximately 4:16 PM. He acknowledged the finding.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726	1. Resident # 235 remains on one-on-one due to his impulsivity and risks for falls. The staff member was immediately counseled and re-educated. 2. All residents assigned a one-on-one were reviewed to ensure staff understood the reason for the one-on-one assignment. Care plans updated. No other resident was affected. 3. Staff was educated on a new protocol for "one-on-one" assignments to reflect the purpose of the monitoring and to ensure that staff understood their role and to not leave a resident unattended without someone relieving them.	3/15/20 3/15/20

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F 726	Continued From page 59 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a nursing assistant had the skill to safely provide 1:1 care for one (1) of 75 residents in the sample (Resident #235). Findings included... Review of Resident # 235's current medical record on 02/19/20, starting at 1:00 PM, showed that the resident was admitted on 12/24/20 with multiple diagnoses, including Alteration in Neurological Status related to Closed head Injury, Seizures, Muscle Weakness, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Continued review of the record revealed a physician order dated 01/21/20, which ordered "1:1 monitoring for safety." Further review of Resident # 235's medical record revealed a nursing note dated 01/27/20 that documented, "At about 6:05 PM, Resident was noted standing up in the lounge ...bleeding from ...left eyebrow measuring 0.5cm (centimeter) X 0.5 cm. Resident stated ...I was making a move forward when I fell and hit my left eye." The nursing note also documented that the resident was transferred by "911" to the nearest emergency room for further evaluation on that same day at 7:18 PM. However, the nursing note	F 726	4. An observation audit will be performed by the Unit Managers/Shift Supervisors on all residents with one-to-one supervision weekly x 4 weeks and then monthly to ensure that one-on-one monitoring is performed appropriately. Results of these audits will be submitted to the QAPI Committee monthly for further review and recommendations.	

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F 726	Continued From page 60 lacked documented evidence that the staff was providing 1 to 1 monitoring for safety before Resident # 235's fall. Further review of the medical record showed a discharge instruction from a local hospital dated 01/27/20 that documented the resident was seen for "Facial laceration [and] Fall." The discharge instructions indicated that the resident's laceration was at the "left lateral near temple." Continued review of the discharge instructions revealed that Resident # 235's "wound was closed with 4 sutures." Review of the Care Plan dated 12/24/19 lacked documented evidence of the staff's responsibility when providing 1 to 1 monitoring for the safety of Resident #235. During an interview on 02/19/20 at 3:00 PM, Employee #2 (DON) and Employee # 7 (Unit Manager) acknowledged the finding and stated that Employee #18 Cetified Nursing Assistant (CNA) "left the resident without waiting for her relief." When asked if Employee #18 received training on 1 to 1 monitoring for safety, Employee #2 and Employee #7 stated, "Yes." However, the facility had no documented evidence of Employee # 18's training or competency on 1 to 1 monitoring for safety. Further interview with Employee #2 and Employee #7 revealed that the facility did not have a policy on "1 to 1 Monitoring for Safety". The facility failed to ensure that Employee #18 (CNA) was competent to provide 1 to 1 monitoring for the safety of Resident #235.	F 726		

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F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732	1. Staff posting was corrected during the survey and posted prominently on each unit. 2. There was no direct adverse outcome to any resident as a result of this finding. 3. The Nursing secretary and unit secretaries were in-serviced by the Regional Clinical Nurse Consultant immediately. Visual rounds validated that the posting were done and accurate. 4. The Nursing Secretary will audit posting of staff daily and report her findings to the QAPI Committee monthly for review and recommendations.	2/12/20 2/12/20

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F 732	Continued From page 62 by: Based on observation and staff interview, facility staff failed to post daily nurse staffing information in a readily accessible location. The resident census on the first day of the survey was 346. Findings included . . . On February 9, 2020 at approximately 7:10 AM there was no posting of the staff information on Units One (1) North, One (1) South, Two (2) North, Two (2) South, Three (3) North and Three (3) South. Upon arrival on the units between 7:00 AM and 7:10 AM Surveyors observed staff erasing information from all of the "grease boards" directly across from the nurses' stations. It was later determined that they were erasing the staffing information from the prior shift (11 PM on 11/8 through 7 AM on 11/9/2020.) In addition, facility staffing information was not observed in readily accessible locations within the facility. During a face-to-face interview on February 14, 2020, at approximately 10:00 AM Employee #2 stated, the daily staffing is posted on the door in the supervisors' office. The writer stated, that this is not a location where residents and visitors can view the form as they would have to enter the supervisors' office because the door is always open. The door has been observed open during our visit (2/9/2020 - 2/14/2020) not allowing me to see the form without first entering the supervisors' office. Therefore, the form has not been readily	F 732		

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F 732	Continued From page 63 available for residents and visitors to review at any given time. Employee #2 acknowledged the finding.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756	1. Resident # 220 medications were reviewed by the Pharmacist on 2/29/20. Resident #23's medications were reviewed and audited to ensure that all of his medications were current and available. His care plan was updated to reflect his hypertensive and diuretic medications as well. 2. The pharmacist performed a review of all resident medications on 2/29/20 to identify medication issues as well as any recommendation for GDRs. All findings were followed-up with the residents' respective physicians and care plan updated accordingly.	

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F 756	Continued From page 64 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, for two (2) of 75 sampled residents, the facility's pharmacist failed to identify a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review for one (1 resident; and to ensure the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (August 2019 and Jaqnuary 2020) for one (1) resident. (Residents #23 and #220). Findings include... 1. During an interview on 02/10/20 at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his hypertension medications for January 2020. Review of Resident #23's current medical record on 02/13/20 starting at 2:00 PM showed that the resident had an initial admission date of 07/30/19 with multiple diagnoses including Essential Hypertension, Cerebral Infarction, and Acute Kidney Failure. Further review of the resident's record revealed a January 2020 Medication Administration Record (MAR) that showed the following: Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) give 1 tablet by mouth one time a day for HTN (Hypertension) with a start date of	F 756	3. The Director of Nursing will in-service Nursing Management and ensure that the pharmacist performs the required drug review of all residents monthly. The Unit Managers will ensure that recommendations are reviewed and addressed by the physician(s) timely. 4. A random audit of 5 residents from each unit will be performed by the Unit managers monthly and reported to the QAPI Committee for further review and recommendation.	3/3 - 3/15/20