| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 |

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| F 656 | Continued From page 25<br>rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview, for three (3) of 75 sampled residents, the facility's staff failed to develop patient-centered Care Plans for: (1) the use of oxygen for one (1) resident; (2) the resistant /refusal of ADL [activity of daily living] care for one (1) resident; and (3) the diagnosis of Adjustment Disorder with Anxiety and Depressed Mood for one (1) resident (Residents' #106, #220 and #235).<br><br>Findings include...<br><br>1. The facility failed to develop a patient-centered Care Plan for Resident #106 use of Oxygen.<br><br>Review of a physician's order for the resident dated September 18, 2019, showed that the resident has an order for "O2 (Oxygen) at 2 liters continuously for SOB (Shortness of Breath)."<br><br>According to the Annual Minimum Data Set dated | F 656 | updating of resident care plans. Resident care plans will be updated, at a minimum, quarterly, annually, and with change of condition to reflect change and focus of their plans of care.<br>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. | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 656 | Continued From page 26<br>November 19, 2019, the resident was coded for receiving Oxygen Therapy.<br><br>However, review of the comprehensive care plans failed to show a comprehensive person-centered care plan for the resident's continuous use of Oxygen.<br><br>A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on February 20, 2020. The employee reviewed the care plans and acknowledged that the facility staff failed to develop a patient-centered Care Plan for Resident # 106's continuous use of Oxygen.<br><br>2. The facility failed to develop a patient-centered Care Plan for Resident #220 use of Oxygen.<br><br>Resident #220 was admitted to the facility on May 22, 2019, with diagnoses that included Quadriplegia Hypertension, Peripheral Vascular Disease, and Anxiety disorder.<br><br>A review of Section C400 of the quarterly Minimum Data Set (MDS) dated December 19, 2019, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident is totally dependent on physical assistance from two or more persons for all aspects of care: bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.<br><br>The resident was observed lying in bed on February 10, 2020, at 2:37 PM when she stated | F 656 | | |

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| F 656 | Continued From page 27<br>to the surveyor, "I need to talk with you, my absorbent brief is only changed once every 8 hours.<br><br>Interview conducted on February 12, 2020, at 1:30 PM with Employee #19 concerning Resident #220 absorbent brief changed only once a shift. The employees stated, "The resident's absorbent brief is changed when the resident request to be changed. She refuses when CNA [Certified Nursing Assistant] goes to change her."<br><br>Interview conducted on February 12, 2020, at 1:40 PM with Employee #20 concerning Resident #220 absorbent brief being changed only once a shift. The employee stated, "The resident [will] refuse or ask that staff to come at a given time for her brief to be changed. I am her CNA I go back to her several times for the day for her to verbalize [when] she is ready to be changed."<br><br>A review of Resident # 220's Care Plans showed there was documented evidence of goals and interventions to address the resident's resistant /refusal of activity of daily living care.<br><br>A face-to-face interview was conducted with Employee #19 at approximately 2:00 PM on February 12, 2020. When asked about the care plan that shows resident resistant /refusal of ADL care plan, Employee #19 reviewed the record and acknowledged the findings.<br><br>3. The facility failed to develop a patient-centered Care Plan to address Resident # 235's diagnosis of Adjustment Disorder with Anxiety and Depressed Mood.<br><br>Review of Resident # 235's current medical | F 656 | | |

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| F 656 | Continued From page 28<br>record on 02/19/20 at 1:00 PM showed that the resident was admitted on 12/24/20 with several diagnoses including Adjustment Disorder with Anxiety and Depressed Mood.<br><br>Continued review of the medical record showed a Care Plan dated 12/24/19 that failed to outline how the staff provided care to address Resident # 235's diagnosis of Adjustment Disorder with Anxiety and Depressed Mood.<br><br>During a face-to-face interview on 02/19/20 at 3:00 PM, Employee #7, Unit Manager, acknowledged the finding. | F 656 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to–<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in | F 657 | | |

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| F 657 | Continued From page 29<br>disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, for five (5) of 75 sampled residents, the facility's staff failed to update Care Plans for : (1) one (1) resident, who fell during care; (2) 1 to 1 monitoring for safety for one (1) resident; (3) two (2) residents, who had a resident-to-resident verbal interaction; and (4) one (1) resident's dialysis information (Residents' #81, #235, #246, #297 and #322).<br><br>Finding include...<br><br>1.The facility's staff failed to update Resident # 81's Care Plan after he fell during care.<br><br>Resident #81 admitted to the facility on 9/21/09, with diagnoses that included: Diabetes Mellitus, Hypertension, Hyperlipidemia, Cerebral Infarction, and Major Depressive Disorder.<br><br>Review of the resident's current medical record showed that while the facility's staff was providing care for Resident #81, he pulled down the left side rails of his bed and fell. Continued review of the medical revealed that the resident had no apparent injuries from the fall on 02/12/20.<br><br>Review of Resident # 81's Annual Minimum Data Set (MDS) dated 09/04/19 showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) resident was coded with a score of | F 657 | 1. Resident #81's mattress was changed to a scoop mattress with bedrails removed and 2-person assist at all times during provision of care. His care plan was updated to reflect these new interventions. Staff was educated to this change in his plan of care on 2/19/20. Resident #235 remains on one-on-one due to his impulsivity and risks for falls. His care plan was also updated to reflect appropriate plans and interventions for the one-on-one monitoring. Resident #246 has been voluntarily discharged home and Resident #297's care plan, although updated with interventions to keep him safe from the other resident, is now discontinued due to the fact that Resident #246 no longer resides in the facility. Resident #322's care plan was updated to reflect the name, address, and contact information of her Dialysis Center.<br>2. The facility recognizes that all residents can be affected by this deficiency, but no negative outcomes have resulted. Care Plans are audited and reviewed daily by the Interdisciplinary Team. | 2/19/20 |

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| F 657 | Continued From page 30<br>"15" which indicated the resident was cognitively intact. Section G (Functional Status) resident was coded as "4" which indicated the resident was totally dependent on staff for locomotion on and off the unit. Section J1800 (Falls) the resident was coded as "1" which indicated the resident had a fall since admission, entry, or reentry, whichever is more recent.<br><br>Review of the previously mentioned resident's Care Plan showed a Focus Area for Falls that lacked documented evidence that the facility's staff updated the Care Plan with goals, approaches, and interventions to address the fall that occurred on 02/12/20.<br><br>During a face-to-face interview conducted on 2/14/20, at approximately 11:00 AM, Employee #9 reviewed Resident # 81's Care Plan and acknowledged the finding.<br><br>2. The facility's staff failed to update Resident # 235's Care Plan to include goals and interventions to address 1 to 1 monitoring for safety.<br><br>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 several diagnoses including Adjustment Disorder with Mixed Anxiety.<br><br>Continued review of the medical record revealed a physician order dated 01/21/20, which instructed the staff to provide 1 to 1 monitoring for safety. | F 657 | 3. The Interdisciplinary Team Members were in-serviced by Regional Nurse Consultant on the appropriate updating of resident care plans. Resident care plans will be updated, at a minimum, quarterly, annually, and with change of condition.<br>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. | 4/9/20 |

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| F 657 | Continued From page 31<br>Further review of the medical record revealed a Care Plan dated 12/24/20 that lacked documented evidence that the facility staff failed to revise the previously mentioned Care Plan to include goals and interventions to address the 1 to 1 safety monitoring for Resident #235.<br><br>The facility staff failed to revise Resident #235 Care Plan to include goals and interventions for 1 to 1 monitoring for safety.<br><br>The facility's staff failed to update Resident # 235's Care Plan to include goals and interventions to address 1 to 1 monitoring for safety.<br><br>3. The facility's staff failed to update Residents' #246 and #297 Care Plan to address a resident-to-resident verbal interaction.<br><br>Resident #246 was admitted to the facility on 9/30/20 with diagnoses that included Cerebral Infarction, Asthma, and Major Depressive Disorder.<br><br>During a face-to-face interview on 02/12/20 at 10:32 AM, Resident #245 was asked about an incident that occurred between her and another resident (Resident #297). Resident #245 stated "[Resident # 297] threaten me...disrespected me. He pushed his walker behind me and went behind me. He went off on me... I had protection with me, a short cheese knife. I don't have it anymore. They (the facility) took it. I used to cut cheese with it. There was no physical altercation between us." | F 657 | | |

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| F 657 | Continued From page 32<br><br>Resident #297 was admitted to the facility on 04/17/18 with diagnoses that included Diabetes Mellitus, Hypertension, Hepatitis C, Alcohol Abuse, and Cannabis Abuse.<br>On 02/20/20, at approximately 1:00 PM, Resident #297 decline to be interviewed by the State Agency Representative.<br><br>During a face-to-face interview with Employee #6 on 2/20/20 at 11:17 AM, she stated, "They [the residents] are on the same unit. They use to be friends. We keep them away from each other. They both know that they have to stay away. They don't smoke at the same time. Whoever gets to the smoking area first, the other one has to wait. Customer Service is aware of this."<br><br>Review of Resident # 246's and # 297's Care Plan(s) showed that the facility's staff failed to update the previously mentioned residents' Care Plans with goals, approaches, and interventions to address the resident-to-resident altercation that occurred on 10/24/19.<br><br>During a face-to-face interview on 02/20/20 at 11:17 AM, Employee #6, Unit Manager, acknowledged the finding.<br><br>4. The facility staff failed to update Resident # 322's Care Plan with the Dialysis Center information.<br><br>Resident #322 was admitted to the facility on 09/27/18, with diagnoses that included End-Stage Renal Disease, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anemia, Sarcoidosis, Cerebrovascular Disease, and History of Falling. | F 657 | | |

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| F 657 | Continued From page 33<br><br>Review Resident # 322's Quarterly Minimum Data Set (MDS) dated 01/27/20 showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) the resident was coded with a score of "09" which indicated that the resident was not cognitively intact. Section I (Active Diagnoses) the resident was coded as I1500 End-Stage Renal Disease and I8000 Other Dependence on Renal Dialysis. Section O0100 [Special treatments, Procedures, and Programs] the resident was coded as "J" indicating the resident received Dialysis treatments.<br><br>Review of the resident's Care Plan showed a Focus Area of "Renal Failure related to End-Stage Disease." However, the Care Plan lacked documented evidence of the name, location, and contact personnel at the dialysis center.<br><br>A face-to-face interview conducted on 02/13/20, at approximately 1:00 PM, Employee #8 stated, "We did not include the Dialysis Center information, but we will include the information immediately." | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | F 684 | 1. 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. Resident 295's eye drops were clarified with the physician and re- | 2/18/20<br><br>2/18/20 |

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| F 684 | Continued From page 34<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review, and interviews, for three (3) of 75 sampled residents, the facility's staff failed to: (1) provide care per the person-centered Care Plan for one (1) resident; (2) provide medication per professional standards and as prescribed by the physician for one (1) resident; and (3) failed to obtain a physician's order to release the resident's body to the DC Medical Examiner for one (1) resident. (Residents' #23, #295, and #TF)<br><br>Findings included...<br><br>(1) The facility's staff failed to provide Resident #23 with care per his person-centered Care Plan.<br><br>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.<br><br>Continued interview revealed that the nurses take his blood pressure daily, and he always requests his readings. Resident #23 said that once his blood pressure reached "189/111," he asked to see the nurse practitioner, who informed him that his blood pressure medication had been "left off the list." The resident also stated, "The last time my blood pressure was that high (189/111). I had a stroke."<br><br>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 that included: Essential Hypertension, Cerebral Infarction, and Acute Kidney Failure. | F 684 | started. Staff will be in-serviced on proper medication administration and documentation. The requirement to get an order to release a body to the medical examiner was reviewed with licensed staff.<br>2. A full-house audit was performed of resident medications to ensure that medications were accurate, available, and current. Any issues identified were corrected.<br>3. Licensed staff was in-serviced on proper medication administration, storage, and documentation by the Chief Operating Officer of Clinical Services and the Director of Nursing.<br>4. Unit Managers will select 5 random resident charts from their respective nursing units every thirty (30) days to ensure resident medications are administered and accounted for. Results of these audits will be reported to the QAPI Committee monthly for further review and recommendations. | 2/18/20 - 3/8/20<br><br>2/12/20 - 3/8/20 |

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| F 684 | Continued From page 35<br><br>Continued review of Resident # 23's medical record revealed a Quarterly Minimum Data Set (MDS) dated 11/06/19. The MDS data showed the following:<br><br>Section C (Cognitive Pattern) the resident had a score of "15", which indicated that the resident's cognitive response was intact; and<br><br>Section I (Active Diagnoses) - the resident had several active diagnoses, including Hypertension and Cerebrovascular Accident.<br><br>Further review of Resident # 23's medical record showed a Care Plan with an initiation date of 07/31/19 with the following focus areas and interventions:<br><br>Focus Area- Hypertension related to lifestyle, Intervention- give antihypertensive medications as ordered ...Amlodipine Besylate tablet 10 milligrams by mouth one time a day; and<br><br>Focus Area- Acute Renal Failure Superimposed on Chronic Kidney Disease, Intervention - give medications as ordered by a physician.<br><br>Further review of the resident's record revealed a January 2020 Medication Administration Record (MAR) that showed the following:<br><br>Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) give one tablet by mouth one time a day for HTN (Hypertension) with a start date of 08/20/19 and a discontinue date of 01/01/20.<br><br>Lasix (Furosemide) Tablet 40 mg (milligram) give one tablet by mouth one time a day for edema | F 684 | | |

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| F 684 | Continued From page 36<br>with a start date of 08/20/19 and a discontinue date of 01/01/20.<br><br>Continued review of the January 2020 MAR showed that the facility's staff failed to administer Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) 1 tablet by mouth one time a day for HTN (Hypertension) and Lasix (Furosemide) Tablet 40 mg (milligram) 1 tablet by mouth one time a day for edema for 19 days starting on 01/02/20 to 01/20/20.<br><br>However, further review of Resident # 23's medical record showed that there was no documented evidence of a physician's order to discontinue the previously mentioned Norvasc or Lasix on 01/20/20.<br><br>Continued review of Resident # 23's medical record showed a nurse practitioner note dated 01/20/20 that documented "Was asked to see pt (patient) for elevated BP (Blood pressure) ... Meds (medications) reviewed. No antihypertensive noted on profile-pt (patient) was previously on Norvasc".<br><br>During a face to face interview on 02/13/20 at 3:00 PM, Employee #2 (DON) and Employee #7 (Unit Manager) acknowledged the findings.<br><br>The facility's nursing staff failed to implement the care plan for the administration of hypertensive and diuretic medications for Resident #23.<br><br>2. The facility's staff failed to ensure Resident #295 received medication per professional standards. | F 684 | | |

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| F 684 | Continued From page 37<br>The manufacture instructions stipulate, "Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf<br><br>Observation of Unit 2 North on 02/09/20 at 8:15 AM, showed a medication cart that contained one (1) bottle of Latanoprost 0.005% with an open date of 12/07/19 written on the bottle, which was a total of nine (9) weeks. Continued observation revealed that the facility's staff failed to follow the manufactures specified storage time of "6 weeks" to store Latanoprost 0.005%.<br><br>Resident #295 was admitted to the facility on 12/19/18 with multiple diagnoses, including Open-Angle Glaucoma.<br><br>Review of the current physician's order directed, "Latanoprost 0.005% instill one drop in both eyes for Open-Angle Glaucoma."<br><br>During a face-to-face interview on 02/09/20 at 8:20 AM, Employee #31 (the charge nurse on duty) acknowledged the finding.<br><br>2B. The facility's staff failed to ensure Resident #295 received medication as ordered by the physician.<br><br>Review of the resident's February 2020 Medication Administration Record (MAR) showed that Resident #295 refused the Latanoprost 0.005% eye drops on 02/09/20 at 8:00 PM.<br><br>A second observation of Unit 2 North on 02/10/20 at approximately 9:20 AM, revealed a medication cart that lacked evidence of Resident # 295's | F 684 | | |

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| F 684 | Continued From page 38<br>prescribed medication of "Latanoprost 0.005%". However, continued observation showed that the previously mentioned medication was stored on the unit unopened in the medication room.<br><br>During a face-to-face interview with Resident #295 on 02/10/20 at approximately 11:30 AM, she stated, "I did not get my eye drops last night ...I never refuse my eye drops." However, an interview with the staff nurse on 02/10/20 at approximately 9:30 AM revealed that the resident's Latanoprost 0.005%" was not delivered by pharmacy until 3:00 AM on 02/10/20.<br><br>During a face-to-face interview on 02/10/20 at approximately 11:00 AM, Employee # 6, Unit Manager, acknowledged the findings.<br><br>The facility staff failed to ensure that Resident # 295's Latanoprost 0.005% eye drops were available for administration on 02/09/20 at 8:00 PM. Also, the facility's staff inaccurately recorded that Resident #295 refused the previously mentioned medication on 02/09/20 at 8:00 PM.<br><br>3. The facility's staff failed to obtain a physician's order to release Resident TF's body to the DC Medical Examiner.<br><br>Resident #TF was admitted to the facility on 11/14/19, with diagnoses that included Dementia, End-Stage Renal Disease, Hypertension, and Anemia Chronic Kidney Disease. The resident expired at the facility on 12/10/2019.<br><br>Review of the nurse's notes dated 12/10/19 revealed, "At about 9:20 AM ...<br>[Medical Director] was made aware ... cause of | F 684 | | |

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| F 684 | Continued From page 39<br>death as ASCVD (Atherosclerotic Cardiovascular Disease), ESRD (End-Stage Renal Disease), DM (Diabetes Mellitus), HTN (Hypertension), Osteomyelitis Left Foot ...Medical Examiner was called by police ...[Family member] call back and stated that let the facility have the medical examiners office pick up the body and they will have [Funeral Home] pick up the body form the DC Medical Examiner's office ..."<br><br>Review of Resident TF's medical record lacked evidence that the facility's staff obtained a physician's order to release the resident's body to the medical examiner.<br><br>During a face-to-face interview with on 02/20/20 at 4:23 PM, Employee #2 acknowledged the findings. | F 684 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interviews for five (5) of 75 sampled residents, the facility's staff failed to: (1) ensure 1 to 1 monitoring (supervision) was provided for one resident; (2) ensure two (2) residents, who were asssessed as fall risks, recieved adequate supervision; and (3) supervise two (2) residents when placing them in | F 689 | 1. Resident # 235 remains on one-on-one due to his impulsivity and risks for falls.<br>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.<br>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 |

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| F 689 | Continued From page 40<br>a ride share car (Uber). for two (2) of 75 sampled residents (Residents' #56, #187, #226, #235, and #305).<br><br>Findings included...<br><br>(1) The facility's staff failed to ensure Resident #235 recieved 1 to 1 monitoring (supervision), as perscibed.<br><br>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."<br><br>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."<br><br>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 lacked documented evidence that the staff was provided 1:1 monitoring for safety prior to Resident # 235's fall on 01/27/20.<br><br>Further review of the medical record showed a | F 689 | 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 689 | Continued From page 41<br>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."<br><br>Continued review of the discharge instructions revealed that Resident # 235's "wound was closed with 4 sutures."<br><br>Review of the Care Plan dated 12/24/19 lacked documented evidence of the staff's responsibility when providing 1:1 monitoring for the safety of Resident #235.<br><br>During an interview on 02/19/20 at 3:00 PM, Employee #2 (DON) and Employee # 7 (Unit Manager) acknowledged the finding. Employee #2 then stated that Employee #18 Cetified Nursing Assistant (CNA) "left the resident without waiting for her relief." When asked if Employee #18 received training on 1:1 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 1:1 monitoring for safety.<br><br>Further interview with Employee #2 and Employee #7 revealed that the facility did not have a policy on "1:1 Monitoring for Safety".<br><br>The facility's staff failed to provide 1 to 1 monitoring (supervision)for Resident #235 on 01/27/20.<br><br>(2). The facility staff failed to ensure Resident #56 and Resident #305, who were asssessed as fall risk(s), recieved adequate supervision. | F 689 | 1. Resident #56's care plan was updated for closer monitoring when she is up and in her wheelchair. Resident #305's care plan was updated with interventions for staff supervision when he is in his room. Residents #187 and #226 should never have been put into any vehicle unescorted by staff or a responsible party. Social Services were counseled by the Administrator immediately. Both residents are still in the facility and doing fine.<br>2. The facility recognizes that all residents have the potential to be affected by these findings. An audit was performed to ensure that resident needs and supervision are provided appropriately.<br><br>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.<br><br>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. | 4/6/20 |

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| F 689 | Continued From page 42<br><br>A. Resident #56 was admitted to the facility on 11/30/1630, with diagnoses that included Hypertension, Peripheral Vascular Disease, Seizure Hypercholesterolemia, Anxiety and Major Depressive Disorder.<br><br>Review of Resident's #56's medical record showed that on 02/07/20 at 9: 00 AM, the resident was found in front of the nursing station lying face down bedside her wheelchair.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS) dated 11/14/19, showed Section C [Cognitive Patterns] a Brief Interview for Mental Status (BIMS) with a score of "13" which indicated that the resident had moderate cognitive impairment Section G (Functional Status) resident is coded as "3" extensive assistance with two (2) persons physical assist for bed mobility and transfer and coded "7" activity occurred only once or twice for locomotion on the unit and locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code "0" indicates No impairment. Section J I700 Fall History on Admission/entry was coded as"0" to indicate that the resident had no fall 2 - 6 months prior to his admission to the facility.<br><br>Review of the Care Plan initiated on 12/01/16 showed "Resident at risk for falling r/t [related to] dx [diagnoses] of Catatonia and Epileptic Seizure Disorder. However, the Care Plan lacked documented evidence that the staff was to monitor Resident #56 while in her wheelchair.<br><br>Continued review of Resident #56's medical record revealed a nursing note dated 02/07/20 at 13:42 that showed "Resident was noted lying | F 689 | | |

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| F 689 | Continued From page 43<br>face down by her wheelchair in front of the nursing station. On assessment resident was noted with a swelling to the right frontal part of head active ROM (range of motion) to both upper and lower extremities done, resident obeys commands, and respond to question spontaneously. LOC (level of conciousness) was within normal, alert verbal responsive. neuro check initiated, ice pack applied to swelling on the frontal part of the head [doctor name] ... gave order to transfer resident to hospital ER (emergency room) for evaluation of swelling to the head post fall ..."<br><br>During a face to face interview on 2/13/20 at 2:55 PM, Employee #21 stated, " Resident was at the nursing station waiting to be picked up for an appointment to the urologist doctor, I placed her there and then went to attend to another resident."<br><br>During a face-to-face interview on 02/13/20 at 1:44 PM, Employee #8; Unit Manager acknowledged the findings and stated, "No one witnessed the resident's fall. The staff assigned to the resident left the resident at the nursing station and went to attend to another resident."<br><br>The facility's staff failed to supervise Resident #56 on 02/07/20 while she was sitting in her wheelchair at the nursing station.<br><br>B. Resident #305 was admitted to the facility on January 18, 2015, with several diagnoses that included Hypertension, Gastroesophageal Reflux Disease, Anemia, Hyperlipidemia, Benign Prostatic Hyperplasia, and Anxiety Disorder. | F 689 | | |

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| F 689 | Continued From page 44<br>Review of Resident #305's medical records revealed a nursing note dated 02/08/20 at 9: 00 AM that showed "The resident was found on the floor, beside his bed and sitting on his buttocks.."<br><br>Review of Resident #305's Quarterly Minimum Data Set (MDS) dated 01/29/20 showed Section C [Cognitive Patterns] a Brief Interview for Mental Status (BIMS) with a score of "13" which indicates the resident had moderate cognitive impairment. Section G [Functional Status] resident is coded as "3" extensive assistance with one (1) person physical assist for bed mobility, transfer, locomotion on the unit, and is coded "1" supervision, oversight, encouragement or cueing for locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code "0" indicates No impairment. Section J I700 Fall History on Admission/entry was coded as"0" to indicate that the resident had no fall 2 - 6 months prior to his admission to the facility.<br><br>Review of the Care Plan initiated on 01/20/15 showed "Resident at risk for falls r/t [related] gait/balance problems, non-adherence to calling for assistance. The Care Plan lacked documented evidence how staff supervise resident while he was in his room unattended.<br><br>Continued review of Resident #305's medical record showed a nursing note dated 2/8/20 at 21:20 that showed, "Around 3:10 PM resident was noted sitting on his buttock on floor. Beside his bed in his room. The resident stated he was trying to sit in his w/c [wheelchair]. Upon assessment ...denied hitting his head. No bruise or injury noted this time. Neuro check initiated. The resident was educated to use the call light for assistance." | F 689 | | |