

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

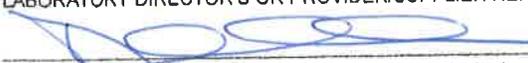
PRINTED: 08/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2015
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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from July 1, 2015 through July 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records, review of facility documentation/video and other documentation as indicated. The facility census the first day of the survey was 159. The Stage 2 survey sample size was 36.</p> <p>Abbreviations/definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; RN - Registered Nurse; RD - Registered Dietician; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MD - Maintenance Director; SD/IC - Staff Development/Infection Control; FSD- Food Service Director; WCN - Wound Care Nurse;</p> <p>ADL/activities of daily living - bathing, eating, toileting and hygiene; AVM/artiovenous malformation - abnormal connection between arteries and veins that may bleed; acute on chronic - an individual with a known chronic illness (anemia) suddenly gets an exacerbation of the particular condition; agitation - emotional state of restlessness;</p>	F 000	<p>Disclaimer Statement: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State laws.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 9/11/2015
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 ambulation/ambulatory - moving about; walking; amputation - removal; Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak; anti-psychotic - medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality; axillary - armpit; B&B - bowel and bladder; BM - bowel movement; BR - bathroom; B/L - bilateral; BUE - bilateral upper extremities; bypass graft - surgical procedure used to treat severe blockage due to plaque in the arteries of the lower extremity; c - with; CAA/Care Area Summary - part of MDS assessment which assists in identifying and planning for potential problem care areas; CBC/Complete Blood Count - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia and infection; cm - centimeter, unit of length; C&S/Culture and Sensitivity - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; cognitive - thinking, memory functions; colon - long, coiled, tubelike organ that removes water from digested food and the remaining material called stool moves through the colon to be excreted; Colonoscopy/Colo - diagnostic test that allows a doctor to examine the colon using a thin, flexible	F 000		

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F 000	Continued From page 2 tube; continent/continence - full control of bladder and/or bowel function; contracture - joint limitations with fixed high resistance to passive stretch of a muscle; c/o - complained of; cystitis - inflammation of urinary bladder; cystoscopy - procedure where a scope is used to examine the bladder; debility - physical weakness; dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DM/diabetes mellitus - disease where blood sugar levels are too high; dialysis - cleansing of the blood by artificial means when kidneys have failed; dx - diagnosis; et cetera - in addition to; EGD/esophagogastroduodenoscopy - diagnostic test that allows the doctor to visualize the inside of the esophagus, stomach and the small bowel; ESRD/End Stage Renal Disease - disease where the kidneys stop working; emesis - vomiting; ER-emergency room; enteral feeding tube - tube used to feed resident directly into the stomach; frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; functional incontinence - when a resident is usually aware of the need to urinate but for a physical or mental reason he/she is unable to get to a bathroom; GI/gastrointestinal - tract that includes the esophagus, stomach, small and large bowels, rectum and anus; GI bleeding/GIB - symptom of a disease that	F 000		

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F 000	Continued From page 3 occurs somewhere along the GI tract; GI diagnostic tests - tests that visualize and identify issues along the GI tract, including EGD and Colonoscopy; GU - Genitourinary/organ system of the reproductive organs and the urinary system; Gastroenterology - medical speciality that focuses on the digestive system and its disorders; heme - blood, component of hemoglobin that binds oxygen; hemocult - test that checks for the presence of hidden blood in the stool; hemoglobin/Hgb - protein in red blood cells that carries oxygen from the lung's to the body's tissues; Hct-hematocrit-ratio of red blood cells to the total volume of blood; hematuria - blood in the urine; hemorrhagic - bleeding; hemorrhoids - enlarged blood vessels at the anus; hospice - service that provides care to residents that are terminally ill; hoyer - mechanical lift used to transfer residents; i.e. - for example; incontinent/incontinence - loss of control of bladder and/or bowel function; Incontinence Pattern Profile/voiding diary - a record of voiding (urinating) and leakage (incontinence) time of urine for 72 hours and/or 3 days; intravenous - administration of medications or fluids through a tube directly into a vein; lateral - farther from the median; relating to the side; MAR/Medication Administration Record - list of resident's daily medications to be administered; MDS/Minimum Data Set - standardized assessment form used in nursing homes;	F 000		

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F 000	Continued From page 4 masses - large body of matter; mg/milligrams - unit of measurement of mass; midsternal - middle of sternum; ml - metric unit of volume equal to one thousandth of a liter; Multiple Sclerosis/MS - abnormal response of the body's immune system directed against the central nervous system (CNS); CNS/Central nervous system - made up of the brain, spinal cord and optic/eyes nerves); myelin - fatty substance that surrounds and insulates the nerve fibers; neurogenic bladder - malfunctioning urinary bladder; necrotic - tissue death, usually due to interruption of blood supply or injury; negative/-; Nephrology - medical speciality that focuses on diseases of the kidneys; occasionally incontinent - less than 7 episodes of incontinence during a 7 day look back period; occult - hidden; offloading - removal of pressure from an area; organisms - various types of bacteria; PAD - Peripheral artery disease; palmar - having to do with the palm of the hand; PEG/Percutaneous Endoscopic Gastrostomy - tube placed through the abdominal wall into the stomach; persistent vegetative state - disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness; POS/Physician Order Sheet - monthly report of resident's active physician orders; Positive/+; Pressure Ulcer - sore area of skin that develops when the blood supply to it is cut off due to pressure;	F 000		

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F 000	Continued From page 5 PPS/Prospective Payment System - MDS assessment used in Long Term Care facilities which sets payment levels based on services being provided; psychosis - loss of contact/touch with reality; PVD/Peripheral Vascular Disease - common circulatory problem in which narrowed arteries reduce blood flow to your limbs; quadriplegia - paralysis of both arms and legs; RR/respiratory rate - rate of breathing; RW - rolling walker; radiating - spreading or moving from one area to another; Santyl - ointment containing enzyme that helps remove dead tissue; sclerosis - scar tissue; serial H&H/hemoglobin & hematocrit - blood tests repeated multiple times; stool - bowel movement; suppository - drug administered into the rectum; suprapubic catheter -[s/p] tube used to drain urine from the bladder; tarry stool - black colored stool that is caused from bleeding somewhere along the digestive tract; transfusions - process of receiving blood products through a tiny tube that is inserted into a vein; tremors - shaking and/or twitching movements; UA/urinalysis - laboratory testing of urine; UTI/Urinary Tract Infection - bacteria in the urine; unstable - change without warning or lack stability; unstageable - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Urology - a surgical specialty which deals with	F 000			

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F 000	Continued From page 6	F 000			
F 202 SS=D	<p>diseases of the male and female urinary tract; urosepsis - severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream; vascular - relating to blood vessels.</p> <p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R159) out of 36 Stage 2 sampled residents, the facility failed to have a discharge summary after R159 was discharged to home. Findings include:</p> <p>R159 was admitted to the facility on 1/6/15 for short-term rehabilitation and discharged to home on 1/22/15.</p> <p>Review of the Discharge Summary, undated, revealed that only R159's name, the name of the attending physician and his signature were filled in on the document. The summary failed to contain other pertinent information such as: admission and discharge dates, admission and</p>	F 202	<p>F202 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE</p> <p>Ex. 1</p> <p>A. R159 suffered no ill effect from the event cited. The discharge summary has been completed.</p> <p>B. All discharged residents have the potential to be affected and the Medical records professional has audited discharges after 7/15/15 to see that a discharge summary is complete for all affected residents.</p> <p>C. Physicians and Medical Director will be in serviced regarding timely completion (within 30 days of discharge) of documentation as it relates to this event by the medical records professional and staff development no later than September 11th. Training will be reviewed at least annually.</p> <p>D. Medical records professional/designee will audit resident record for timely (Within 30 days of discharge) and accurate completion of discharge summary. Medical records professional/designee will report findings through QAPI process until 100 % compliance has been achieved. (Attachment 1)</p>	9-11-15	

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F 202	Continued From page 7 discharge diagnoses, discharge condition, summary, discharge instructions and prognosis.	F 202	Please see previous page	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility failed to ensure that R159's discharge summary was completed. Findings were confirmed with E2 (DON) on 7/14/15 at 9:45 AM.</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on multiple observations, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity. Findings include:</p> <p>During the lunch observation in the C wing hall on 7/1/15, the following were observed:</p> <ol style="list-style-type: none"> At 12:40 PM, E8 knocked on R90's door and entered with the resident's lunch tray. E8 did not ask for permission to enter. At 12:45 PM, E13 (LPN/UM) knocked on R181's door and entered with the resident's lunch tray. E13 did not ask for permission to enter. At 12:48 PM, E13 knocked on R110's door and entered with the resident's lunch tray. E13 did not ask for permission to enter. 	F 241	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>Example 1: Ex. 1 A. R90 suffered no ill effect from the event cited. All staff have been in-serviced by Staff Development to ask permission before entering the room. B. All residents have the potential to be affected since staff need to enter the room periodically. All staff have been in-serviced by Staff Development that they must knock and ask permission before entering any room. C. All staff will be in serviced regarding dignity as it relates to this event by Staff Development by September 11th. Training will be reviewed annually by union and non-union staff. D. UM/Supervisors will observe 2 room entry opportunities on each unit, (6); on each shift (3); for compliance (22% sample) daily X 14, weekly X 2, monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2) Ex. 2 A. R181 suffered no ill effect from the event cited. All staff have been in-serviced by Staff Development to ask permission before entering the room. B. All residents have the potential to be affected since staff need to enter the room periodically. All staff have been in-serviced by Staff Development that they must knock and ask permission before entering any room. C. All staff will be in serviced regarding dignity as it relates to this event by Staff Development by September 11th. Training will be reviewed annually by union and non-union staff. D. UM/Supervisors will observe 2 room entry opportunities on each unit, (6); on each shift (3); for compliance (22% sample) daily X 14, weekly X 2, monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2) Ex. 3 A. R110 suffered no ill effect from the event cited. All staff have been in-serviced by Staff Development to ask permission before entering the room. B. All residents have the potential to be affected since staff need to enter the room periodically. All staff have been in-serviced by Staff Development that they must knock and ask permission before entering any room. C. All staff will be in serviced regarding dignity as it relates to this event by Staff Development by September 11th. Training will be reviewed annually by union and non-union staff. D. UM/Supervisors will observe 2 room entry opportunities on each unit, (6); on each shift (3); for compliance (22% sample) daily X 14, weekly X 2, monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2)</p>	<p>9-11-15</p> <p>9-11-15</p> <p>9-11-15</p>

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F 241 Continued From page 8

F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations in Stage 1 and interviews made during the environmental tour of the facility, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior involving 6 out of 6 halls in the facility. The disrepairs included unpainted and peeled paint from walls, holes in the walls, dirty floors, et cetera in the rooms and/or bathrooms. Findings include:

During Stage 1 of the survey on 7/1/15 from 10:55 AM to 4:26 PM and 7/2/15 from 9:03 AM to 1:22 PM, the following observations were made:

On 7/1/15 the following findings were observed in the B wing of the facility:

1. Room B8 had the following:
 - behind 8A's bed there was an approximately 2 - 3 inch hole in the wall;
 - exposed telephone wires that hung out of the wall, attached to a telephone outlet, that dangled above the floor.

F 241 F253
483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES
Example #1
A. In Room B8 the hole in the wall and exposed telephone wires have been repaired by Maintenance.
B. All residents have the potential to be affected.

F 253
C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.
D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.
9-7-15

Example #2
A. Room B14 will be repainted and a vendor has been contacted to replace the cabinet door.
B. All residents have the potential to be affected.
C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.
D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.
9-7-15

Example 3
A. The sink drain in room B4 has been unclogged.
B. All residents have the potential to be affected.
C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.
D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.
9-7-15

Example 4
A. The loose air conditioner cover has been repaired, the baseboards under the window have been dusted, and the bathroom sink has been unclogged in room C8.
B. All residents have the potential to be affected.
C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.

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F 253	<p>Continued From page 11</p> <p>On 7/2/15, the following findings were observed in the D wing of the facility:</p> <p>13. Room D5's bathroom had the following: - both toilet grab bars had peeled paint; - a basin was stored on the bathroom floor that was unlabeled and unbagged; - there were 3 yellow unlabeled and uncovered toothbrushes stored in the bathroom.</p> <p>14. Room D7's bathroom had the following: - grab bars, towel bars and sink fixtures were discolored, tarnished and rusted; - toilet base caulking was in disrepair and discolored; - toilet commode seat was stored on the floor under the sink and on 7/14/15 at 12:10 PM the commode seat was stored on the floor under the sink again.</p> <p>15. Room D5's bathroom toilet base caulking had a dark discoloration.</p> <p>On 7/2/15, the following findings were observed in the E wing of the facility:</p> <p>16. Room E3 had the following: - wall on the top right above the bathroom door had two areas that were plastered and unpainted; - bathroom grab bars had peeled paint.</p> <p>17. Room E5's bathroom had the following: - grab bars near the toilet had peeled paint; - an unlabeled and unbagged basin was stored on the floor under the sink and it was observed again on 7/14/15 at 12:25 PM; - there were 3 yellow unlabeled and uncovered toothbrushes stored in the sink area and on</p>	F 253	<p>F253 Continued from previous page</p> <p>C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.</p> <p>D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.</p> <p>Example 12</p> <p>A. In Room C2, the flooring has been replaced, the toilet re-caulked, new sinks and grab bars have been delivered for installation. Resident suffered no ill effect from the event cited. Personal care items were removed and stored appropriately.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.</p> <p>D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. UM/Supervisor will observe two rooms for appropriate placement of personal care products on each hallway (6) on each shift (3) for compliance daily x14, weekly x 2, monthly x 2 until 100 compliance (Attachment 2) Results will be reported through the QAPI process.</p> <p>Example 13</p> <p>A. For Room D5, grab bars have been delivered for installation. Resident suffered no ill effect from the event cited. Personal care items were removed and stored appropriately.</p> <p>B. All residents have the potential to be affected.</p> <p>C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified.</p> <p>D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. UM/Supervisor will observe two rooms for appropriate placement of personal care products on each hallway (6) on each shift (3) for compliance daily x14, weekly x 2, monthly x 2 until 100% compliance (Attachment 2) Results will be reported through the QAPI process.</p> <p>Example 14</p> <p>A. For Room D7, new sinks and grab bars have been delivered for installation and the toilet has been re-caulked. Resident suffered no ill effect from the event cited. Personal care items</p>	<p>9-7-15</p> <p>9-7-15</p> <p>9-7-15</p>

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808			
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F 253	Continued From page 12 7/14/15 at 12:25 PM it was observed again. On 7/2/15, the following findings were observed in the F wing of the facility: 18. Room F1 had the following: - ceiling tiles above the bed on the A side (door side) had multiple stains; - multiple small holes in walls around A bed; - wall behind A bed had unpainted spackled areas; - hole at the edge of the sprinkler head above A bed; - chipped bathroom sink; - bathroom counter had a piece of it missing; - sink's caulking was discolored and cracked; - hook on wall not secured (on 7/14/15 at approximately 12:20 PM, E17 (MD) stated it was for a hose that was no longer in use); - corners of the floor were dirty; - door frame was chipped; - commode seat cover was not secure, one hinge was broken; - non-skid strips on the floor were not secured, they were curled upward. 19. Room F9 had the following: - bedroom door was chipped; - cracked ceiling above and behind A bed; - wall on A side was in disrepair and the drywall was chipped; - white substance spilled in front of the 3 drawer night stand; - multiple small holes in the walls of the bedroom; - curtain was not hung properly; - caulking around the sink counter was cracked and discolored; - toilet bowl was black inside; - caulking at the toilet base was cracked;	F 253	F253 Continued from previous page were removed and stored appropriately. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. UM/Supervisor will observe two rooms for appropriate placement of personal care products on each hallway (6) on each shift (3) for compliance daily x14, weekly x 2, monthly x 2 until 100% compliance (Attachment 2) Results will be reported through the QAPI process. Example 15 A. In Room D5, the toilet base has been re-caulked. B. All residents have the potential to be affected C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 16 A. In Room E3 the wall will be sanded and re-painted, and new grab bars have been delivered for installation. B. All residents have the potential to be affected C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 17 A. For Room E5, new grab bars have been delivered for installation and the toilet has been re-caulked. Resident suffered no ill effect from the event cited. Personal care items were removed and stored appropriately. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident	9-7-15	9-7-15	9-7-15

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F 253	Continued From page 14 - multiple holes in the walls (on 7/14/15 at approximately 11:02 AM, E17 (MD) stated it was from the bathroom grab bars that were removed and never caulked). 23. Room F10 had the following: - overhead bed light was missing a cover; - bedside table was chipped; - wall behind the bed had chipped drywall; - corner wall by the floor next to the dresser on the A side of the room had chipped drywall. - protruding screws in the wall; - bathroom door frame had chipped paint; - bathroom wall had scratched paint in several places; - discolored caulking behind the faucet; - cracked caulking underneath the towel holder; - floor was dirty in the corners; - floor around the toilet was separated from worn off caulking. 24. Room F17 had the following: - drawer handle of a bedside table hanging off; - air conditioner vent was dirty; - corners of the bathroom floor were dirty; - sink's caulking was cracked and discolored; - leaking faucet even when turned off; - rusted vent on the wall next to the sink; - chipped bathroom door frame on the right side. 25. Room F8 had the following: - peeled paint on the windowsill; - air conditioner vent was dirty; - wall behind the bed on the B side of the room had chipped drywall; - wall behind the TV had numerous small holes; - peeled paint on the bathroom door frame; - deep scratch on the bathroom door; - wall on the right side had chipped drywall and	F 253	F253 Continued from previous page painted where patched. New wall mount inks have been delivered to replace any damaged sinks and counters. The toilet has been re-caulked. The bathroom floor will be replaced if dirt cannot be removed. The door frame will be repaired and repainted. B. All residents have the potential to be affected C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 21 A. In Room F4 A-side, spackled walls will be sanded and painted. The drawer handle has been secured, and the over bed table has been replaced. B. All residents have the potential to be affected C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 22 A. In Room F14, both the windowsill and bathroom door frame have been re-painted. New wall mount sinks have been delivered to replace any damaged sinks and counters. Toilet base has been re-caulked and the wall will be patched and re-painted. B. All residents have the potential to be affected C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 23 A. In Room F10, the overbed light cover has been replaced. The bedside table has been repaired. The protruding screws have been removed and the walls will be patched, sanded, and re-painted. The bathroom wall and doorframe will be re-painted.	9-7-15 9-7-15 9-7-15

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808
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F 253	<p>Continued From page 15 scratches;</p> <ul style="list-style-type: none"> - sink counter was chipped in the front; - sink's caulking was cracked; - outlet on the wall by the sink was unpainted; - hole in the wall behind the toilet paper holder; - toilet caulking was cracked and parts of it was black in color; - bathroom floor corners were dirty; - wall vent was rusty. <p>26. Room F6 had the following:</p> <ul style="list-style-type: none"> - protruding nails in the wall; - cracks in the ceiling on the A side of the room; - floor with remnants of non skid strips that were removed in front of TV; - peeled paint next to the clock on the wall inside door; - dried white liquid on the left side of the bedside table; - closet door in disrepair with scratches at the bottom; - floor tiles had missing pieces that were inside the entry door on both sides; - hole and peeled paint around the toilet paper holder; - corners of the floor were dirty; - sink's caulking was cracked and discolored; - corner of the sink was chipped; - vent was rusted. <p>On 7/2/15, the following findings were observed in the G wing of the facility:</p> <p>27. Room G11's wall next to the window had peeled paint.</p> <p>The above findings were confirmed and still present during the environmental tour with E17 (MD) from 10:00 AM to 1:00 PM on 7/14/15.</p>	F 253	<p>F253 Continued from previous page Wall mount sinks have been delivered to replace any damaged sinks and counters. The bathroom floor will be replaced if dirt cannot be removed and the toilet will be re-caulked. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example 24 A. In Room F17, the drawer handle has been repaired; the air conditioner vent has been cleaned. The bathroom floor will be replaced if dirt cannot be removed. Wall mount sinks have been delivered to replace any damaged sinks and counters. The faucet has been repaired. The vent cover will be repaired and the bathroom door frame has been re-painted. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process Example 25 A. In Room F8, the windowsill has been re-painted; the air conditioner vent has been cleaned. Drywall areas and holes identified will be patched, sanded, and re-painted. Door will be replaced if scratch cannot be repaired. Wall mount sinks have been delivered to replace any damaged sinks and counters. The faucet has been repaired. The toilet paper holder will be repaired and the bathroom will be repainted. The bathroom floor will be replaced if dirt cannot be removed and the toilet will be re-caulked. The vent will also be replaced. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through</p>	<p>9-7-15</p> <p>9-7-15</p>
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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 605 GREENBANK ROAD WILMINGTON, DE 19808		
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F 253	Continued From page 16 In an interview with E6 (SD/IC) on 7/14/15 at 12:50 PM, E6 confirmed the basins should not have been stored on the floor and the toothbrushes should not have been unlabeled in the bathrooms. The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior involving all 6 halls.	F 253	F253 Continued from previous page the QAPI process Example 26 A. In room F6, the protruding nails have been removed and patched, and the ceiling cracks have also been repaired. The non-skid strip remnants will be scraped away. The bedside table was cleaned. The closet door is being evaluated for repair or replacement. The floor tiles will be replaced. Holes will be patched and painted. Wall mount sinks have been delivered to replace any damaged sinks and counters. The vent will be replaced. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.	9-7-15	
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to provide adequate and comfortable lighting levels for 3 (E10B, D6B and C7B) out of 40 resident rooms. Findings include: During Stage 1 of the survey, the following were observed: 1. On 7/1/15 at 2:13 PM, the top light setting on the overbed light was not working in room E10B. 2. On 7/1/15 at 4:21 PM, the overbed light was not working in room C7B. 3. On 7/1/15 at 4:26 PM, only one of three settings worked on the overbed light in room D6B.	F 256	Example 27 A. In room G11, the wall has been re-painted. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms and bathrooms to identify Maintenance and Housekeeping needs (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure rooms are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. F256 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING Example #1 A. The overbed light has been fixed in room E10B. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms to ensure overbed lights are functioning properly. (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure	9-7-15	

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F 256	Continued From page 17 During the environmental tour with E17 (MD) on 7/14/15 from 10:00 AM until 12:50 PM, the above listed findings continued to exist. E17 confirmed the findings.	F 256	F256 Continued from previous page compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure they are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	Example #2 A. The overbed light has been fixed in room C7B. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms to ensure overbed lights are functioning properly. (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure they are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process. Example #3 A. The overbed light has been fixed in room D6B. B. All residents have the potential to be affected. C. The preventive maintenance schedule has been revised to include rounds for complete, regular inspection of all resident rooms to ensure overbed lights are functioning properly. (Attachment 6). Repairs will be completed as identified. D. The MD or designee will audit 100% of resident rooms and bathrooms to ensure compliance. MD or designee will examine 3 resident rooms on each hallway (6) to ensure they are in good repair (22% sample) daily for 14 days, then two times per week for two weeks and then three times per month until 100% compliance has been observed. MD will report findings through the QAPI process.	9-7-15	9-7-15

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F 272	Continued From page 18 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews and review of facility documentation, it was determined that for three (R45, R157 and R166) out of 36 Stage 2 sampled residents, the facility failed to comprehensively assess R45's, R157's and R166's urinary incontinence upon admission/readmission to the facility. Findings include: Cross refer F315, example 1 1. Review of R45's clinical record revealed the following: 1/14/15 - R45 was admitted to the facility with diagnoses that included dementia, memory loss and hematuria. 1/14/15 - R45's admission Incontinence Assessment and Evaluation (IAE) identified the resident as frequently incontinent and that a voiding diary was indicated. 1/14/15 - At 2:00 PM, a 3-day (72 hours) voiding diary was initiated and completed on 1/17/15, to help identify R45's voiding pattern and to develop an individualized toileting schedule. It stated "Check resident every two (2) hours, place an x in the appropriate box (toileted, Void, BM, Wet, Dry), R if refuses to be toileted."	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS Ex. 1 A. R45 no longer resides in the facility and had been discharged 5/20/15 prior to survey and identification of the deficiency; therefore it could not be corrected. B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission. C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11 th . The incontinence policy will be reviewed annually by all nursing staff. D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting. Ex. 2 A. R157 remains incontinent; unchanged from prior to admission. A Voiding Diary was completed by nursing and resident remains q2h check and change. B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission. C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11 th . The incontinence policy will be reviewed annually by all nursing staff. D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.	9-11-15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0885004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2015
NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808		
(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 272	<p>Continued From page 19</p> <p>The facility is expected to use this resident observation and communication as the primary source of information when initiating and completing an individualized toileting schedule for R45.</p> <p>Review of R45's voiding diary revealed that the facility failed to complete all areas of the assessment. The voiding diary completed by the CNAs revealed that R45 was not toileted and/or checked every 2 hours for 21 out of 40 opportunities (52.5 %).</p> <p>The facility failed to conduct a comprehensive and accurate assessment of R45's voiding pattern to provide appropriate care and services as related to a toileting schedule for this resident.</p> <p>Findings were reviewed with E2 (DON) and E7 (RN/UM) on 7/14/15 at approximately 3:00 PM.</p> <p>Cross refer F315, example 2 2. R157 was admitted to the facility on 1/9/15 with diagnoses that included dementia with behaviors.</p> <p>The nursing admission assessment, dated 1/9/15, revealed that R157 was occasionally incontinent of urine.</p> <p>The IAE, dated 1/9/15, stated that R157 was frequently incontinent of urine, which contradicted the 1/9/15 nursing admission assessment. A 3-day voiding diary was started that evening.</p>	F 272	<p>Ex. 3</p> <p>A. R166 no longer resides in the facility and had been discharged 5/8/15 prior to survey and identification of the deficiency, therefore it could not be corrected.</p> <p>B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission.</p> <p>C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11th. The incontinence policy will be reviewed annually by all nursing staff.</p> <p>D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.</p>	9-11-15	

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F 272	<p>Continued From page 20</p> <p>R157 was sent to the ER on 1/10/15 at approximately 10:00 PM and returned to the facility at 4:00 AM on 1/11/15. The 3-day voiding diary resumed at 4:00 AM when R157 returned to the facility. Review of the voiding diary revealed that it was incomplete as there were missing blocks of time on 1/11/15, specifically from 12:00 AM through 4:00 AM and from 3:00 PM through 11:00 PM.</p> <p>The admission MDS assessment, dated 1/16/15, stated that R157 was frequently incontinent of urine.</p> <p>R157 was admitted to the hospital on 1/28/15 and readmitted to the facility on 1/30/15. The 1/30/15 nursing admission assessment, under the GU section, was blank and it lacked evidence of R157's urinary incontinence. However, the assessment noted that R157 was readmitted with a diagnosis of UTI.</p> <p>The IAE, dated 1/30/15, revealed that R157 was frequently incontinent of urine. However, the facility failed to identify on the evaluation if a voiding diary was initiated and if there were contributing diagnoses, i.e. UTI, to which the facility wrote "n/a" (non-applicable) despite R157's readmission diagnosis of a UTI. The facility failed to comprehensively assess R157's urinary incontinence, initiate a voiding diary and list contributing diagnoses upon readmission to the facility.</p> <p>R157 was sent to the ER on 2/23/15 at approximately 11:20 AM and returned to the facility at 9:00 PM with diagnoses that included UTI. The facility again failed to comprehensively assess R157's urinary incontinence and failed to</p>	F 272	Please see previous page		

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F 272	<p>Continued From page 21 complete a 3-day voiding diary upon return to the facility.</p> <p>The IAE, dated 3/14/15, revealed that R157 was frequently incontinent of urine. However, the facility failed to identify if a voiding diary was initiated and list contributing diagnoses. In addition, the IAE contradicted R157's clinical record which indicated she was always incontinent of urine.</p> <p>The facility failed to comprehensively assess R157's urinary incontinence and they failed to complete a 3-day voiding diary since admission to the facility, despite multiple readmissions.</p> <p>Findings were reviewed with E4 (RN/UM) on 7/15/15 at 8:59 AM. Cross refer F315, example 3 3. R166 was admitted to the facility on 2/23/15 with diagnoses that included dementia and a history of UTI and urosepsis.</p> <p>The nursing admission assessment, dated 2/23/15, under the GU section was not completed.</p> <p>The IAE, dated 2/23/15, stated R166 was alert and oriented to person and place, had no short term memory loss, and required moderate assistance with ADLs. R166's continence status was not completed on the evaluation. It failed to identify whether R166 was continent or incontinent, if a voiding diary was initiated, if there were any contributing diagnoses, and failed to identify how much assistance R166 required with ambulation, transfers and toileting assistance.</p> <p>R166's clinical record revealed that on 2/23/15 a</p>	F 272	Please see previous page	

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F 272	<p>Continued From page 22</p> <p>voiding diary was started. Instructions on the voiding diary stated, "Check resident every two (2) hrs, place an X in the appropriate box. R if refuses to be toileted." The diary dates listed were 2/23/15, 2/24/15 and 2/26/15 (unclear if this was a dating error and was actually 2/25/15). Review of the voiding diary revealed it was incomplete, as there was a lack of documentation every two (2) hours as directed. In fact, on all three days there was no documentation on the 7 AM to 3 PM shift. Review of the voiding diary revealed that on 2/24/15, R166 was noted to be "wet" at 1:00 AM, 6:00 AM and 3:00 PM. On 2/26/15, R166 was noted to be "wet" at 2:00 AM, 6:00 AM, 4:00 PM and 9:00 PM. Contrary to what was documented on the voiding diary, which was completed by CNAs, the CNA ADL Flow Sheet documented R166 as always continent of bladder during the MDS assessment time period (2/24/15 through 3/2/15). The facility failed to ensure that a complete voiding diary was done.</p> <p>A nurse's note, dated 2/26/15 and untimed, stated "... Continent of B&B c some incontinence at times ...".</p> <p>The admission MDS assessment, dated 3/2/15, stated that R166's daily decision making skills were moderately impaired, that she required limited assist of one (1) staff for transfers, and required extensive assist of one (1) staff for toilet use and hygiene. The 3/2/15 MDS assessment also stated R166 was always continent of bladder during the assessment period (2/24/25 through 3/2/15), despite evidence of incontinence noted on the voiding diary on 2/24/15 and 2/26/15, and as noted in the 2/26/15 nurse's note.</p> <p>During an interview on 7/13/15 at 11:10 AM, E14</p>	F 272	Please see previous page	

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F 272	Continued From page 23 (RNAC) confirmed the nursing admission assessment was incomplete under the section GU, confirmed the IAE and voiding diary were incomplete, and that the voiding diary noted R166 to be "wet." In an interview with E13 (LPN/UM) on 7/13/15 at approximately 11:30 AM, E13 confirmed the nursing admission assessment, IAE and voiding diary were all incomplete. E13 confirmed the voiding diary noted R166 to be "wet," while the same CNAs completing the diary documented this resident as being continent at those times. E13 stated it was the UM who was to review the voiding diary. E13 confirmed she had not looked at or reviewed R166's voiding diary. In an interview on 7/13/15 at approximately 2:30 PM, E2 confirmed the findings. The facility failed to accurately and comprehensively assess R166's urinary status upon admission, they failed to identify this resident was at times incontinent, and they failed to complete a voiding diary.	F 272	Please see previous page	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP A. R157 remains incontinent; unchanged from prior to admission. A Voiding Diary was completed by nursing and resident remains q2h check and change. B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission. C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11 th . The incontinence policy will be reviewed annually by all nursing staff. D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.	9-11-15

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808
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F 280	<p>Continued From page 24</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R157) out of 36 Stage 2 sampled residents, the facility failed to revise R157's urinary incontinence care plan. Findings include:</p> <p>Cross refer F315, example 2 On 1/16/15, R157 was care planned for frequent urinary incontinence with approaches that included toileting upon request or per scheduled toilet plan.</p> <p>On 2/14/15, R157's urinary incontinence care plan was revised to include the approach of "toilet program added".</p> <p>On 3/4/15, R157's care plan for frequent incontinence of urine was revised to "... d/c (discontinue) toilet plan 2 (secondary) debility & functional inc. (incontinence) r/t (related to) dementia." The facility failed to revise the care plan to reflect that R157 declined from frequently to always incontinent of urine and it lacked evidence of an alternate intervention in place of the discontinued toileting program.</p>	F 280	Please see previous page	
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F 280	Continued From page 25 On 3/20/15, the significant change MDS assessment revealed that R157 was always incontinent of urine. The facility failed to ensure R157's care plan was revised to reflect her current urinary incontinence status and intervention implemented in place of the discontinued toileting program. Findings were reviewed with E4 (RN/UM) on 7/15/15 at 8:59 AM.	F 280	Please see previous page	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined that the facility failed to ensure that the services provided in medication administration via PEG tube for one (R41) out of 36 Stage 2 sampled residents met professional standards of quality. Findings include: The facility's policy #114 on Medication Administration via Enteral Feeding Tube (PEG tube) stated, "Procedure: #18. Pour liquid medication (one at a time) or water with crushed tablets into syringe and allow it to flow by gravity. Follow with 15 ml water flush " 7/1/15 at approximately 9:30 AM, R41 (resident in a persistent vegetative state) was to receive a	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS A. R41 suffered no ill effect from the event. E21 was corrected on the spot by surveyor in the presence of E2 (DON). R41's peg tube was assessed and found to be functioning and patent. B. All residents who receive medications through a tube have the potential to be affected and their peg tubes have been evaluated for function and patency. C. E21 will in-service in conjunction with Staff-developer all licensed staff regarding appropriate medication delivery technique by September 11 th . Training will be reviewed annually by all nursing staff. D. Staff developer will audit 2 PEG medication administrations (Attachment 4) to observe appropriate medication administration weekly X4, monthly X2 and report findings through QA process.	9-11-15

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F 281	Continued From page 26 blood pressure lowering medication via a PEG tube. E21 (LPN) was observed crushing the medication and mixing it with water. After correctly checking for placement of the PEG tube in the stomach, E21 removed the plunger from the syringe and attached the syringe to the PEG tube. Using the syringe like a funnel, E21 poured in 30 ml of water to flush the tube. When the water failed to go down via gravity, E21 used the plunger to push the water down. E21 then poured the water with crushed medication into the syringe and the solution did not go down by gravity. E21 used the plunger again to push water to flush the tube after administering the medication. E21 did not attempt other methods for clearing the tube such as, repositioning R41, checking for kinks in the tube, adjusting the height of the syringe, gently pushing and pulling the plunger in syringe, using warm water and checking for leaks to ensure that the tube was clear of debris, and if all attempts failed, notifying the charge nurse or RN/unit manager.	F 281	Please see previous page	
F 309 SS=D	This finding was reviewed with E2 (DON) and E21 (LPN) on 7/8/15 at 12:15 PM. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING A. R28 was readmitted on 7/22/15 with a diagnosis of Anemia of Chronic Disease, consistent with expected progression of renal disease. R28 did not experience a "GI bleed". As reported in this 2567 on page 33, R28's Hemoglobin was tracked and reported multiples times in March, April, May, and June. Per primary care physician and hospital Cardiologist R28's chest pain is "non-cardiac" and is not related to his expected anemia of chronic disease. Upon re-admission, R28's hemoglobin was obtained per physician order and results communicated upon receipt to the physician. R28 no longer resides in the facility. B.. There are no hemodialysis residents in the facility at this time. Should any new or existing resident require hemodialysis, the corrective action developed will be implemented for those resident(s). C. Receiving Nurse, post dialysis, will communicate weekly with dialysis center for lab results. Results will be documented in resident medical record for physician review. D. UM/designee will audit (Attachment 5) lab results weekly x 4, monthly x 2 and report findings through QAPI.	9-11-15

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F 309	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, review of facility documentation and other documentation, the facility failed to provide the necessary care and services to attain the highest practicable physical well-being in accordance with the plan of care for 1 [one] (R28) out of 36 Stage 2 sampled residents. For R28, the facility failed to have a communication system in place to consistently monitor his hemoglobin (Hgb). Findings include: 1. R28 was admitted to the facility on 3/19/03 with diagnoses that included ESRD requiring dialysis, anemia, history of AVM in the stomach and a history of GI bleeding. 7/10/12 - R28 was care planned for risk for low hemoglobin related to diagnoses of anemia and history of GI bleed, last reviewed on 5/6/15, with approaches that included to assess for any signs and symptoms of bleeding and notify the doctor if noted; and labs per orders and call the doctor with abnormal results. The goal was to maintain a stable hemoglobin. 1/4/15 - A nurse's note, timed 10:00 PM, stated that R28 returned from dialysis with a script to do stool hemocults x 3 for occult blood. 1/4/15 - A physician's order, timed 10:00 PM, stated to hemocult stool three times for occult blood. 1/23/15 - A nurse's note, timed 10:30 AM, stated that R28 had a positive hemocult. 1/23/15 - A physician's order stated to discontinue	F 309	Please see previous page	

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808		
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F 309	<p>Continued From page 28 hemoccult and consult GI service.</p> <p>1/27/15 - The annual MDS assessment stated that R28 was cognitively intact and required total assistance of one staff person for toileting.</p> <p>3/20/15 - A GI consultation report stated, "Pt (patient) apparently with heme (+) stool, however not sure how often/when this happened. Pt is unable to provide any medical information. We called NH (nursing home) and could not provide any more info. Pt has had occult GIB/anemia in past due to AVMs. Last EGD/Colo 2010 ... Recommendations: (1) Repeat CBC ...; (2) Heme (check) and document what stool look like x 3 ...; (3) T/C (to consider) repeat EGD/Colo pending above. Daughter needs to be part of discussion as Pt not able; ...".</p> <p>3/20/15 - A nurse's note, timed 11:00 PM, stated, "N/O (new order) CBC ... on Monday 3/23/15. Hemoccult stool & document what stool looks like x 3 days."</p> <p>3/21/15 - A nurse's note, timed 10:00 AM, stated, "Clarification order to collect 3 stool samples for Hemoccult instead of Hemoccult stool & document what stool looks like x 3 days. Nurse to document what stool looks like & notify the MD (medical doctor) if necessary."</p> <p>3/23/15 - R28's lab results revealed that his hemoglobin level was 10.8.</p> <p>3/25/15 - A nurse's note, untimed, stated that R28 had a positive hemoccult of one brown formed stool.</p> <p>3/27/15 - A progress note, written by E20 (NP),</p>	F 309	Please see previous page		

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F 309	<p>Continued From page 29</p> <p>stated that R28 was seen and examined for positive heme stool and pain to his left hip and left shoulder. The note also stated that R28 lacked evidence of current active bleeding. However, the note stated to send R28 to the ER for further evaluation of left hip pain, left shoulder pain and anemia. This progress note was not in R28's clinical record, but was located in another resident's record after R28 was hospitalized on 7/1/15 according to an interview with E4 (RN/UM) on 7/15/15 at 2:10 PM.</p> <p>3/27/15 - Review of the hospital ER record revealed that R28's hemoglobin was 10.8.</p> <p>3/27/15 - A nurse's note, timed 5:30 PM, stated that R28 returned from the ER with no new orders and requested to follow up with his doctor. R28 was given pain medication in the ER.</p> <p>3/29/15 - A progress note, written by E31 (doctor), did not address R28's (+) heme stools.</p> <p>4/5/15 - A nurse's note, timed 3:05 PM, stated, "... collected hemoccult. (+) results noted ...".</p> <p>4/5/15 - A nurse's note, timed 10:25 PM, stated that "... (+) hemoccult result ...".</p> <p>4/8/15 - A progress note, written by E20 (NP), stated that "... recent (+) heme stools. No obvious bleeding currently ... Hgb 10.8 on 3/23 ... (1) Hemoccult stool - stable for now, will reconsult GI for further workup if hemoglobin is > (sic) 8.0 ...". It was unclear how R28's hemoglobin was being consistently monitored by nursing as the clinical record revealed the absence of a physician's order to monitor his hemoglobin. In addition, this progress note was not in R28's clinical record, but</p>	F 309	Please see previous page	

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F 309	<p>Continued From page 30</p> <p>was located in another resident's record after R28 was hospitalized on 7/1/15 according to an interview with E4 on 7/15/15 at 2:10 PM.</p> <p>4/27/15 - The quarterly MDS assessment stated that R28 had a moderate cognitive impairment and required total assistance of one staff person for toileting.</p> <p>4/27/15 - The nutritional assessment stated that R28's hemoglobin level on 4/23/15 was 11.4.</p> <p>5/2015 - The dialysis form entitled "Tracking My Numbers" stated that R28's hemoglobin's goal was 10.0 - 11.0.</p> <p>5/29/15 - The nutritional progress note stated that R28's hemoglobin level on 5/19/15 was 11.0.</p> <p>6/20/15 - A progress note, written by E31 (doctor), did not address R28's (+) heme stools.</p> <p>6/30/15 - A nutritional progress note stated, "... Resident's monthly dialysis report (labs and weight) was faxed to the facility by dialysis RD - Labs of June 9 & June 23, 2015 as follows ... Hgb 10.4 & 9.7 ... discussed ... lab results with resident ...". R28's clinical record lacked evidence of any communication between the facility and dialysis after his 6/30/15 treatment regarding the further decline in his hemoglobin level to 8.5.</p> <p>7/1/15 - A nurse's note, timed 10:31 PM, stated "... c/o midsternal chest pain ... resident upgraded pain to radiating down L (left) arm and to back and stated he feels bad ... transported to ... hospital ...".</p> <p>7/2/15 - According to the hospital record, timed</p>	F 309	Please see previous page	

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4:56 AM, R28's hemoglobin dropped to a critical level of 5.8.

7/2/15 - Review of the hospital record, timed 2:21 PM, revealed a nephrology consultation which stated, "... presented to the hospital with complaint of chest pain ... going on for proximally 2 days ... sharp in nature ... radiated to the shoulder ... associated with shortness of breath ... In the emergency room he was found to have a hemoglobin of 7 which dropped further to 6.4 today ... called the outpatient dialysis unit and they report that hemoglobin was 11.2 and dropped to 10.4 then 9.7 then 8.5 ... last dialyzed on ... June 30 ... He likely has an element of acute on chronic anemia. Acute anemia may be related to GI blood loss ... Clearly hemoglobin has been trending down for some time. He deserves a GI workup ... We should follow serial H&H ...".

7/2/15 - The hospital history and physical, timed at 11:45 PM, stated, "... hemoglobin 6.4 ... anemia, which is acute on chronic. rule out GI bleeding. Consult with gastroenterology ...".

7/7/15 - In an interview, timed 9:33 AM, this surveyor asked E4 what was the hospital status of R28. E4 stated that R28's hemoglobin level was unstable and the hospital needed to stabilize it before doing an EGD and Colonoscopy.

7/7/15 - In an interview, timed 10:24 AM, E4 was asked how the facility communicated with the dialysis center. E4 stated that the dialysis center will call the facility with new orders as R28 used to hold onto the paperwork that was sent back with him. E4 also stated that E30 (RD) communicates with dialysis regarding nutrition, labs and weights. It was at this time that the

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F 309	<p>Continued From page 32</p> <p>surveyor requested a copy of all labs taken at the dialysis center since March 2015.</p> <p>Review of the nutritional assessment/progress notes since March 2015 revealed only 4 hemoglobin results (4/23/15, 5/19/15, 6/9/15 and 6/23/15) out of 13 obtained during his dialysis treatments, which accounted for 30%.</p> <p>7/7/15 - Review of the list of dialysis labs that were faxed to the facility at 11:55 AM revealed the following:</p> <ul style="list-style-type: none"> - 3/24/15 through 4/23/14, R28's hemoglobin ranged from 10.2 to 11.4 (which met/exceeded his dialysis goal of 10.0 - 11.0); - 4/28/15 - Hgb 9.9 - 5/5/15 - Hgb 9.8 - 5/12/15 - Hgb 11.1 - 5/19/15 - Hgb 11.0 - 5/26/15 - Hgb 11.4 - 6/2/15 - Hgb 11.2 - 6/9/15 - Hgb 10.4 - 6/16/15 - Hgb 9.7 - 6/23/15 - Hgb 9.7 - 6/30/15 - Hgb 8.5 <p>7/7/15 - The hospital record, timed 1:44 PM, revealed that R28 underwent an EGD which showed no source of bleeding. However, the hospital record revealed that R28 was having black, tarry stools, a sign of bleeding, and his hemoglobin level continued to be unstable.</p> <p>7/14/15 - Review of the hospital records, timed 2:47 PM, revealed that R28 underwent a Colonoscopy. The results revealed that the colon preparation was inadequate; stool in the colon limited the exam; no obstructing masses and no bleeding found; and internal hemorrhoids.</p>	F 309	Please see previous page	

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F 309	Continued From page 33 7/15/15 - Findings were reviewed with E4 at 2:10 PM. It was at this time when E4 showed the 3/27/15 and 4/8/15 NP's progress notes and stated that they were found in another resident's clinical record. The facility failed to have a communication system in place to consistently monitor R28's hemoglobin after having positive heme stools. R28's clinical record lacked evidence of consistent monitoring of R28's hemoglobin by nursing. R28 became symptomatic with chest pain and shortness of breath resulting in a hospitalization from 7/1/15 to 7/22/15 for low hemoglobin that required multiple blood transfusions and GI diagnostic testing.	F 309	Please see previous page		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and review of facility documentation, it was determined that for 2 (R51 and R118) out of 36 Stage 2 sampled residents, the facility failed to provide the necessary services for dependent residents to maintain good oral and personal hygiene. The facility failed to ensure that R51 received good oral hygiene during AM care. The facility failed to ensure that R118, who was	F 312	F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Ex. 1 A. Oral care was provided prior to 3pm that day for R51 who suffered no ill effect from the cited event. B. All residents dependent upon staff for oral care have the potential to be affected. The staff member responsible for the cited event was disciplined and re-trained. C. All care giving staff will be in serviced regarding appropriate and timely Oral Care by Staff Development prior to September 11 th . Training will be reviewed by all licensed nursing staff at least annually. D. UM/Supervisors will examine 2 residents on each unit (6) on each shift (3) to ensure oral care is provided appropriately (22% sample) daily X 14, weekly, X 2, and monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2) Ex. 2 A. R118 who suffered no ill effect from the cited event received personal hygiene (bed baths and showers) for the period cited As of July 1 st , resident received showers as scheduled.. B. All residents dependent upon facility staff have the potential to be affected. The shower policy remains in place, however the procedure via the Shower Schedule form (attachment 7) has been revised to more accurately track hygiene as well as provide for resident choice. C. All care giving staff will be in serviced regarding ADL care to residents that may refuse care by Staff development prior to September 11 th . Shower Schedule form is revised (Attachment 7). Training will be reviewed by all licensed nursing staff at least annually. D. UM/Supervisors will examine 2 residents on each unit (6) on each shift (3) to ensure personal hygiene is provided appropriately (22% sample) daily X 14, weekly, X 2, and monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2)	9-11-15 9-11-15	

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F 312	<p>Continued From page 34</p> <p>unable to carry out his personal hygiene independently, received showers as necessary to maintain good personal hygiene. Findings include:</p> <p>1. R51 was admitted to the facility on 7/30/11. On 10/31/13, the facility developed a care plan for R51's inability to do his own ADLs without assistance. The care plan stated that R51 required extensive to maximum assist with ADLs. The care plan, last revised on 4/21/15, included the approach, "provide resident with oral hygiene equipment and assist resident as per needs, staff to supervise a.m. and p.m. if unsuccessful with care, call wife."</p> <p>According to the quarterly MDS assessment, dated 4/15/15, R51 was severely impaired (unable to make own decisions) for daily decision making and was totally dependent on one staff person for personal hygiene.</p> <p>On 7/7/15 at 6:55 AM, an observation was made of E19 (CNA) providing R51's shower. E19 brought R51's toiletry supplies, including a toothbrush, still in the plastic cover, and toothpaste into the shower room. Once R51 was showered, dressed and wheeled out of the shower room, the toothbrush was placed in the dresser in his room.</p> <p>In an interview on 7/7/15 at 1:04 PM, E19 revealed that R51's toothbrush was still in the package. E19 confirmed that oral care was not done and that she did not attempt to do it during his shower or in the morning.</p> <p>On 7/7/15 at 1:06 PM, findings were reviewed with E7 (RN/UM).</p>	F 312	Please see previous page		

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F 312	<p>Continued From page 35</p> <p>The facility failed to provide the necessary services to maintain oral hygiene for R51 when staff failed to provide oral care during AM care or provide oral care at any time during the morning of 7/7/15.</p> <p>2. The facility's standard procedure as noted on the residents' Shower or Whirlpool Schedule form stated: "1. Shower or Whirlpool must be given as scheduled. 2. If any resident refuses a shower/whirlpool, the charge nurse must be notified. 3. Charge nurse must visit resident to determine an alternate time or day. 4. Charge nurses are to countersign next to aides initials for each shower or whirlpool refused. 5. Charge nurse must re-schedule resident if shower/whirlpool is refused. 6. Nail care and shave to be done with each shower or whirlpool. 7. Document as SH (shower) or WP (whirlpool) on Personal Care Record. 8. Bedbaths are not to be given in place of showers or whirlpools. 9. Notify charge nurse when taking resident into shower room so nurse can do assessment."</p> <p>2/8/15 - R118 was re-admitted to the facility from an acute hospital with diagnoses that included dementia.</p> <p>2/15/15 - The admission MDS assessment indicated that R118's cognitive skills for daily-decision making were moderately impaired (makes poor decisions and needed to be cued and supervised). He was dependent on staff for his ADLs, including personal hygiene.</p>	F 312	Please see previous page	

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F 312	<p>Continued From page 36</p> <p>4/21/15 - R118's care plan (originally initiated on 1/15/15) stated, "Unable to do own ADLs without assistance, Resident requires: needs cues, extensive assistance for hygiene and dressing; extensive to maximum assist, may fluctuate up and down secondary to dementia." The goals stated that staff would anticipate and meet the needs of the resident to the extent required by the resident and as the resident allowed. The care plan approaches included: assist resident with dressing, hygiene care as to extent required ... assist resident in showering and/or bathing as per resident needs.</p> <p>According to the CNA ADL Flowsheets dated 4/15, 5/15 and 6/15, R118 was scheduled to have showers twice a week (8 or 9 times a month) on the 7-3 PM shift every Monday and Thursday.</p> <p>Review of R118's CNA ADL Flow Sheets revealed the following:</p> <p>4/15 - R118 received 5 out of 9 scheduled showers during the month. He received bed baths on the 4 other scheduled shower days.</p> <p>5/15 - R118 received 4 out of 8 scheduled showers. He received bed baths on the 4 other scheduled shower days.</p> <p>6/16 - R118 received bed baths on the day shift and/or evening shift on his 8 scheduled shower days.</p> <p>7/9/15 at 10:15 AM - E19 (CNA, assigned to R118's care the majority of the time) was interviewed. She stated that she told the charge nurse each time R118 refused the shower.</p>	F 312	Please see previous page	
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F 312	Continued From page 37 However, there was a lack of evidence to support that the facility's standard procedure was implemented every time R118 refused to shower to indicate that showers were provided to R118 on alternate times and/or days. The facility failed to ensure that appropriate measures to provide showers for R118, who was dependent on staff to perform his personal hygiene, such as showers, and had the potential to refuse, were implemented according to facility's standard procedure. This finding was reviewed with E7 (RN/UM) on 7/9/15 at approximately 9:45 AM and E2 (DON) on 7/15/15 at approximately 5:30 PM.	F 312	Please see previous page	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R175) out of 36 Stage 2 sampled residents, the facility failed to provide the necessary treatment and services to prevent new pressure ulcers from developing. For R175, who was admitted with two pressures ulcers, the	F 314	F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES A. R175 no longer resides in the facility. R175 was placed on a pressure relieving low air loss, alternating pressure mattress upon admission as well as off loading R175's remaining heel. R175's boot was removed on May 5 th . B. All newly admitted residents have the potential to be affected by the event cited. An audit form to prevent unordered devices that have the potential to cause skin breakdown has been developed as well as 24 hour chart checks to identify discrepancies, if any. C. Licensed staff will be in-serviced regarding accuracy of transfer and admission orders, and the proper use of Attachment 8 by Staff Development prior to September 11 th . Training will be reviewed by all licensed nursing staff at least annually. D. Wound care nurse will audit admission skin assessment to reconcile resident condition with physician's orders weekly x4, monthly x2. Wound care nurse will resolve inconsistencies with physician, as soon as practical, document on audit form, (Attachment 8) and report through QAPI.	9-11-15

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F 314	<p>Continued From page 38</p> <p>facility failed to prevent a new ulcer from developing when an offloading boot was applied without a physician's order which resulted in an unstageable pressure ulcer on her left calf. Findings include:</p> <p>R175 was admitted to the facility on 4/28/15 with diagnoses including a recent admission to hospice and end stage dementia.</p> <p>The facility's Skin Integrity Action Sheet, dated 4/28/15, stated that R175 had an offloading boot upon admission.</p> <p>On 4/28/15, R175 was care planned for potential for alteration in skin integrity and approaches included to assess skin every 2 hours and as needed and report any changes to the doctor. R175's care plan lacked evidence of an offloading boot to the left foot.</p> <p>Review of R175's physician's orders revealed the absence of an order for an offloading boot.</p> <p>On 5/5/15, the Weekly Wound Assessment stated that a new pressure ulcer measuring 3 cm x 5 cm with black necrotic tissue was identified on R175's left calf.</p> <p>A physician's order, dated 5/5/15, stated to cleanse the area with normal saline, apply Santyl, cover with a moist gauze and wrap daily until resolved.</p> <p>On 5/11/15, the Wound Care Specialist Evaluation stated that R175 had an unstageable pressure ulcer on the left calf with 100% black necrotic tissue. Treatment was changed to skin prep and a foam dressing daily. The evaluation</p>	F 314	Please see previous page

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F 314	Continued From page 39 also stated, "wound may have been caused by blue offloading boot - will discontinue." A physician's order, dated 5/11/15, stated to discontinue the Santyl and start skin prep to the left calf wound until resolved and to "float calf on pillow at all times." On 5/17/15 at 10:00 PM, R175 passed away. In a combined interview on 7/9/15 at 8:36 AM, E26 (LPN/WCN) stated that R175 was wearing the blue offloading boot, E26 removed it and found the unstageable pressure ulcer on her left calf. E26 described the boot as a soft, light blue boot that extended up to her mid-calf. E14 (RNAC) stated that R175 was not care planned for the blue offloading boot as there was no physician's order for it. The facility failed to provide the care and services for R175 to prevent the development of a pressure ulcer when a blue offloading boot was applied without a physician's order which resulted in an unstageable pressure ulcer on her left calf. Findings were reviewed with E5 (RN/UM) on 7/15/15 at 10:56 AM.	F 314	Please see previous page	
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Ex. 1 A. R45 no longer resides in the facility and had been discharged 5/20/15 prior to survey and identification of the deficiency; therefore it could not be corrected. B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission. C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11 th . The incontinence policy will be reviewed annually by all nursing staff. D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.	9-11-15

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F 315	<p>Continued From page 40</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of other facility documentation including hospital records, it was determined that the facility failed to ensure three (R45, R157 and R166) out of 36 Stage 2 sampled residents, who were incontinent of bladder, received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All three residents experienced a decline in continence and developed UTIs. Two of the three residents (R45 and R157) required hospital evaluation and treatment. For R45, R157 and R166, the facility failed to comprehensively assess their urinary incontinence; failed to complete voiding diaries; failed to individualize toileting plans; and failed to prevent UTIs, resulting in the decline of their urinary continence. Findings include:</p> <p>The facility's "Bowel and Bladder Protocol" last revised in 10/2009 stated, Purpose: "... to provide an individualized method to assist residents to restore bowel and bladder control ... Procedure: Each resident will have ... Bladder assessment completed on admission, quarterly, annually and where there is a change in condition. If it is determined that the resident may benefit from the B&B training, the charge nurse will initiate the forms and inform the staff to start the toileting process and the time span that will be used for this resident. The flow sheet will be used to record bowel and bladder function. The Unit Manager or designee will review the resident's</p>	F 315	<p>Ex. 2</p> <p>A. R157 remains incontinent; unchanged from prior to admission. A Voiding Diary was completed by nursing and resident remains q2h check and change.</p> <p>B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission.</p> <p>C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11th. The incontinence policy will be reviewed annually by all nursing staff.</p> <p>D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.</p> <p>Ex. 3</p> <p>A. R166 no longer resides in the facility and had been discharged 5/8/15 prior to survey and identification of the deficiency; therefore it could not be corrected.</p> <p>B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission.</p> <p>C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11th. The incontinence policy will be reviewed annually by all nursing staff.</p> <p>D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.</p>	<p>9-11-15</p> <p>9-11-15</p>

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F 315	<p>Continued From page 41</p> <p>progress and care plan. The interventions are determined to be used for the resident's individual toileting needs."</p> <p>The facility used the following forms as tools to assess residents incontinence: 1 - Incontinence Assessment and Evaluation (IAE), completed on admission, quarterly and PRN (as necessary). 2 - Incontinence Pattern Profile also known as the voiding diary. It stated to "Check resident every two (2) hours, place an x in the appropriate box (toileted, Void, BM, Wet, Dry, R if refused to be toileted)."</p> <p>According to the American Medical Directors Association's (AMDA/The Society for Post-Acute and Long-Term Care (LTC) Medicine) Clinical Practice Guideline for Urinary Incontinence stated, "... Urinary incontinence should be managed, can often be modified, and sometimes be significantly improved or eliminated in frail older adults, including people with dementia who reside in LTC facilities. Use of the systematic approach ... should help caregivers and practitioners optimized the management of urinary incontinence in the LTC setting ... A bladder record or voiding diary may help to characterize the patient's incontinence ... Outcomes that may be expected from the implementation ... include ... Better identification of individuals who have a reversible urinary incontinence problem. More individualized approaches to urinary incontinence management ... Reduction in the number of significant complications of urinary incontinence ...". Refer to: http://www.amda.com/tools/guidelines.cfm</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 42</p> <p>1. The following information was found in facility documentation for R45. 1/14/15 - admission date to the facility. Nurse's note, dated 1/14/15 timed 5:10 PM stated, "Admitting DX: dementia, memory loss, gait abnormality, hematuria ...".</p> <p>1/14/15 - admission bladder incontinence assessment via facility's "Incontinence Assessment and Evaluation" form scored resident as frequently incontinent. The assessment identified that a "Voiding Diary" was indicated.</p> <p>1/14/15 - 3-Day (72 hours) voiding diary was initiated at 2:00 PM and completed on 1/17/15, to help identify R45's voiding pattern and to develop an individualized toileting schedule.</p> <p>Review of R45's voiding diary indicated that the facility failed to complete all areas of the assessment. The voiding diary completed by the CNAs revealed that R45 was not toileted and/or checked every 2 hours for 21 out of 40 opportunities (52.5 %).</p> <p>In addition, review of the CNA ADL Flowsheet used to record bladder function for each shift, for the dates of 1/14/15 through 1/17/15, revealed that the CNAs documented that R45 was continent of bladder 16 times and was incontinent 5 times, which contradicted the 3-day voiding diary.</p> <p>1/21/15 - The admission MDS assessment stated that R45's cognitive skills for daily decision-making were moderately impaired (poor decisions and needed cues and supervision).</p>	F 315	Please see previous page	
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F 315	<p>Continued From page 43</p> <p>R45 used the wheelchair to move between locations in his room, needed extensive assistance of one staff for all ADLs including use of the toilet. R45 was frequently incontinent of urine.</p> <p>R45 was on a daily fluid pill for a swollen left leg.</p> <p>1/21/15 - The facility initiated a care plan for R45 entitled, "Incontinence of Bladder: Frequently" with a goal based on assessed needs for "Resident will remain odor free and free of skin imp. (impairment) x (times) 92 days." The goal of the care plan was not specific for resolving the triggered area to restore as much normal bladder function as possible and to prevent UTI.</p> <p>Approaches included: "1) Assist resident with inc. (incontinence) care as required; 2) Provide inc. products as needed; 3) Ensure residents dignity and privacy; 4) Weekly skin checks by nurse as scheduled; 5) Toilet upon request or per scheduled toilet plan; 6) Report any skin change to MD (doctor)."</p> <p>1/2015 CNA ADL Flowsheets revealed that R45 continued to have a mixture of continent and incontinent episodes, however, there was no scheduled toileting plan in place.</p> <p>2/2015 CNA ADL Flowsheets showed that R45's voiding assessment lacked any continent episodes. R45's bladder continence declined from the admission assessment of frequently incontinent of bladder to always incontinent of bladder.</p> <p>2/16/15 - care plan was revised and the following interventions were added: "7) res.(resident)</p>	F 315	Please see previous page	

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continency may fluctuate up and down depending upon res. mood and willingness to participate ... dementia dx; 8) Toilet every 3 hours ... as res. allows." The goal of the care plan was not revised.

Review of CNA ADL Flowsheet charting for 2/15, 3/15, 4/15 and 5/15, indicated that R45 was on an every 3 hour toileting program. However, it also indicated that R45 had only one episode of continent voiding.

Despite the fact that the facility documented the decline in R45's bladder continency, implemented an every 3 hour toileting schedule as per revised care plan dated 2/16/15, without evidence to support documentation of a re-assessment and analysis of a 3 day voiding diary.

4/20/15 - The quarterly MDS assessment indicated that he was now always incontinent of bladder. This indicated a decline in R45's urinary continence from previously frequently incontinent on admission.

5/11/15 - A nurse's note, timed 1:25 PM, stated that R45 had blood in his urine, clots and the physician was called. R45 was subsequently sent to the ER for further evaluation. Review of the hospital record revealed that R45 was admitted to the hospital on 5/11/15.

5/20/15 - Hospital Discharge Summary stated,

"... The patient was seen by ... urology. It was concluded that this patient's hematuria was perhaps due to hemorrhagic cystitis because of the enterococcus (name of organism causing infection) UTI. The patient had a cystoscopy ...

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F 315	<p>Continued From page 45</p> <p>evacuation of clot and fulguration (destruction of tissues by means of a high frequency electric current). Condition of discharge: stable."</p> <p>7/6/15 - In an interview at 1:50 PM, E2 (DON) stated that an "incontinent assessment and evaluation is initiated on admission, quarterly and as necessary. If a resident was found incontinent, a voiding diary is initiated over 3 days; 1-2 hours on the first 3 days and the marking of findings are captured in the voiding diary and the care plan is customized accordingly. Whenever we notice changes in pattern, we do a voiding diary."</p> <p>It was unclear how the facility could proceed with an individualized toileting program without a complete voiding diary.</p> <p>Although the facility had a system in place to provide restoration of bladder function and/or to prevent UTIs, the facility failed to ensure their system was appropriately implemented for R45. As a result, R45's urinary function declined from being frequently incontinent to always incontinent of urine within 90 days of admission to the facility. Additionally, R45 had to be hospitalized due to symptoms of hematuria and he underwent surgery to remove the blood clots in his bladder.</p> <p>7/13/15 Review of the facility's Infection Control Surveillance report revealed there was a high number of UTIs from 1/15 through 5/15.</p> <p>7/14/15 at approximately 3:00 PM, findings were reviewed with E2, E7(LPN/UM) and E6 (SD/IC).</p> <p>2. R157 was admitted to the facility on 1/9/15 with diagnoses that included dementia with behaviors.</p>	F 315	Please see previous page		

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F 315	Continued From page 46 1/9/15 - The nursing admission assessment revealed that R157 was occasionally incontinent of urine. 1/9/15 - The IAE revealed that R157 was alert and oriented to person, had short and long term memory loss, required minimum assistance with ADL's including toileting, and was dependent with one staff assist for ambulation and transfers. The evaluation stated that R157 was frequently incontinent of urine, which contradicted the 1/9/15 nursing admission assessment. A 3-day voiding diary was started that evening. 1/10/15 - A nurse's note, timed 9:56 PM, stated that R157 was sent to the ER for further evaluation of her combative behavior. 1/11/15 - A nurse's note, timed 8:00 AM, stated that R157 returned from the ER at 4:10 AM. 1/11/15 - The 3-day voiding diary resumed at 4:00 AM when R157 returned to the facility. Review of the voiding diary revealed that it was incomplete as there were missing blocks of time on 1/11/15, specifically from 12:00 AM through 4:00 AM and from 3:00 PM through 11:00 PM. 1/12/15 - A physician's order stated to obtain a UA C&S for change in mental status. 1/15/15 - R157 tested positive for the flu and was ordered anti-viral medication for 5 days. 1/16/15 - The admission MDS assessment revealed that R157 was severely impaired for daily decision making and required extensive assist of one staff person with toileting. The same	F 315	Please see previous page	

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F 315	<p>Continued From page 47</p> <p>MDS assessment also stated that R157 was frequently incontinent of urine.</p> <p>1/16/15 - R157's UA C&S results revealed that the urine specimen had mixed flora (contaminated). E9 (NP) ordered to repeat the UA C&S on 1/16/15.</p> <p>1/16/15 - R157 was care planned for frequent urinary incontinence with approaches that included assisting her with incontinence care as required and toileting her upon request or per scheduled toilet plan. The clinical record lacked evidence of a scheduled toileting plan.</p> <p>1/16/15 - The CAA/MDS reference note stated that R157 was "experiencing multiple behaviors since admission ... (+) for influenza ... will ask to toilet ... some continent episodes noted ... acute infection may be affecting resident ... need to resolve infections & continue psych (psychological) f/u (follow up) to see if resident adjusts to LTC & (and) behaviors reduce ...".</p> <p>1/20/15 - R157's UA C&S result was negative for infection.</p> <p>1/28/15 - A nurse's note, timed 2:10 PM, stated R157 had a low-grade fever, was exhibiting tremors, was responsive, but weak, and unable to stand to transfer from the wheelchair to the bed.</p> <p>1/28/15 - A physician's order stated to send R157 to the ER for further evaluation.</p> <p>1/28/15 - R157 was admitted to the hospital with a diagnosis of UTI and treated with intravenous fluids and intravenous antibiotics.</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 48</p> <p>1/30/15 - R157 was readmitted to the facility. The nursing admission assessment, timed 6:00 PM, was incomplete as it lacked evidence of R157's urinary incontinence. However, the assessment noted that R157 was readmitted with a diagnosis of UTI.</p> <p>1/30/15 - A nurse's note, timed 11:20 PM, stated that R157 returned to the facility at 6:00 PM with an order for an oral antibiotic for 7 days to treat the UTI. In addition, the nurse's note stated to refer to the nursing admission assessment for a detailed head to toe assessment, which was incomplete as it lacked evidence of R157's urinary incontinence.</p> <p>1/30/15 - The IAE revealed that R157 was frequently incontinent of urine. The facility failed to identify if a voiding diary was initiated on the evaluation and if there were contributing diagnoses, i.e. UTI, to which the facility wrote "n/a" (non-applicable) despite R157's readmission diagnosis of a UTI. The facility failed to comprehensively assess R157's urinary incontinence upon readmission to the facility even after she returned with a hospital documented diagnosis of a UTI and they failed to initiate a 3-day voiding diary.</p> <p>1/31/15 - Review of CNA documentation from 1/9/15 through 1/31/15 revealed that R157 was incontinent of urine on 28 out of 61 shifts (46%).</p> <p>2/3/15 - R157's history and physical stated that E15 (physician) reviewed the 1/30/15 nursing admission assessment, which failed to identify that R157 was frequently incontinent of urine.</p> <p>2/9/15 - A nurse's note, timed 11:30 PM, stated</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 49 that R157 was having "increased behavior this shift".</p> <p>2/10/15 - A physician's order stated to obtain an UA C&S due to a change in mental status.</p> <p>2/12/15 - R157's UA C&S result was negative with two organisms.</p> <p>2/13/15 - A physician's order stated, "Cipro (antibiotic) ... x (times) 7 days..." for UTI.</p> <p>2/14/15 - R157's urinary incontinence care plan was revised to include the approach of "toilet program added". The toilet program consisted of toileting R157 upon rising, before meals (only lunch and dinner) and at bedtime. It was unclear from R157's clinical record how the facility individualized this toileting program when R157 lacked a comprehensive assessment and a completed 3-day voiding diary for urinary incontinence.</p> <p>2/18/15 - A nurse's note, timed 3:00 AM, stated that R157 remained incontinent of urine.</p> <p>2/20/15 - Review of R157's MAR revealed that the last dose of her antibiotic was given during the morning of 2/20/15.</p> <p>2/22/15 - A nurse's note, timed 10:55 AM, stated that R157 was very lethargic (drowsy and difficult to arouse) this shift.</p> <p>2/22/15 - A nurse's note, timed 2:40 PM, stated that R157 was "... found unresponsive ... to sternal (chest) rubs ... 150/65 (blood pressure), 107 (pulse), RR 22 (respiratory rate), 101.3 axillary (temperature from armpit) ... (positive)</p>	F 315	Please see previous page	
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F 315	<p>Continued From page 50</p> <p>emesis (vomiting) during care ... appeared twitchy in face and BUE ... call for Dr. ... gave ... Tylenol suppository ... axillary temp came down to 100.4. (no) twitch and became responsive to name ... new order: ... Cipro (antibiotic) ... monitor for increase temperature ...".</p> <p>2/22/15 - A physician's order, timed 2:40 PM, stated, "Cipro ... x seven days dx UTI".</p> <p>2/23/15 - A nurse's note, timed 11:20 AM, stated that R157 was "... refusing meds (medications) & not eating or drinking ... (new order) to send out to ER for further evaluation ...".</p> <p>2/23/15 - A nurse's note, timed 9:00 PM, stated that R157 returned from the ER with diagnoses of UTI and dementia with no new orders, referred to E15 (physician), and that she was incontinent of urine. R157 continued on Cipro that was ordered on 2/22/15. The facility failed to comprehensively assess R157's urinary incontinence and failed to complete a 3-day voiding diary.</p> <p>2/27/15 - A physician's order stated to obtain the UA C&S results from the 2/23/15 hospital ER visit.</p> <p>2/28/15 - Review of CNA documentation from 2/1/15 through 2/28/15 revealed that R157 was incontinent of urine for 83 out of 84 shifts (99%).</p> <p>3/2/15 - R157's UA C&S result of 2/23/15 was positive and revealed two different organisms, that were not sensitive to the current antibiotic, Cipro.</p> <p>3/3/15 - A physician's order stated to discontinue Cipro and start Bactrim DS (antibiotic) for seven</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 51 days for a diagnosis of UTI.</p> <p>3/4/15 - A nurse's note, timed 11:00 PM, revealed a new order to discontinue R157's toileting program due to it not being effective. Review of R157's clinical record revealed the absence of a physician's order to discontinue R157's toileting program. In addition, it was unclear in R157's clinical record how the toileting program was individualized, evaluated and revised to meet her needs as she required assistance with toileting before it was discontinued. Further review of R157's record revealed the absence of any further attempts by the facility to achieve and/or maintain R157's urinary function or improve as much as possible.</p> <p>3/4/15 - R157's care plan for frequent incontinence of urine was revised with the statement "per staff 2 person A (assist) c transfer, too weak to toilet, no participation in toileting - no cont (continent) episodes noted - d/c (discontinue) toilet plan 2o (secondary) debility & functional inc. (incontinence) r/t (related to) dementia." The care plan was not revised to reflect that R157 declined from frequently incontinent to always incontinent of urine and what intervention was implemented in place of the discontinued toileting program.</p> <p>3/14/15 - The IAE revealed that R157 required minimum assistance with toileting, was frequently incontinent of urine, and dependent upon 1 staff assist for ambulatory and transfer status. The facility failed to identify if a voiding diary was initiated and if there were any contributing diagnoses. In addition, the evaluation contradicted R157's clinical record which indicated she was always incontinent of urine and</p>	F 315	Please see previous page	
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F 315	<p>Continued From page 52 required more than minimal assistance.</p> <p>3/20/15 - The significant change MDS assessment revealed that R157 was severely impaired for daily decision making, had an acute change in mental status, required extensive assist with 2 staff with transfers, and required total assist of one staff person with toileting. The same MDS assessment also stated that R157 was always incontinent of urine.</p> <p>3/20/15 - A CAA/MDS reference note stated that R157 had "multiple infections since admission Influenza ... 1/15/15, 2/11/15 UA was (-) but treated, 2/22/15 UA treated c antib (antibiotic), to ER 2/23/15 + UA cont (continue) antib, rec'd (received) C&S from (hospital ER) on 3/3/15 & needed further antib ... some med changes ... toileting was trialed 2/14 but then d/c'd (discontinued) 3/4/15 as resident unable to participate (secondary) debility ... behaviors decreased ...".</p> <p>Review of CNA documentation for March - May 2015 revealed: - May 2015 - R157 was incontinent of urine for 93 out of 93 shifts (100%); - April 2015 - R157 was incontinent of urine for 83 out of 90 shifts (92%); - May 2015 - R157 was incontinent of urine for 93 out of 93 shifts (100%).</p> <p>6/3/15 - The IAE revealed that R157 required total care for toileting, was always incontinent of urine and dependent with two staff assist and hoyer transfer. The evaluation failed to identify if a voiding diary was initiated and if there were any contributing diagnoses.</p>	F 315	Please see previous page		

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F 315	<p>Continued From page 53</p> <p>Review of CNA documentation for June 2015 and July 1-10, 2015 revealed:</p> <ul style="list-style-type: none"> - June 2015 - R157 was incontinent of urine for 90 out of 90 shifts (100%); - July 1-10, 2015 - R157 was incontinent of urine for 30 out of 30 shifts (100%). <p>7/14/15 - In an interview at 4:33 PM, E18 (CNA) stated that R157 was on a toileting program, but is not anymore. E18 also stated that she routinely checks R157 every two hours and a hooyer lift was required for transfers.</p> <p>7/15/14 - At 8:59 AM, findings were reviewed with E4 (RN/UM).</p> <p>The facility failed to provide the care and services to maintain and/or prevent a decline in bladder function as much as possible and to prevent UTIs which resulted in a decline in R157's urinary continence from frequently to always incontinent as evidenced by:</p> <ul style="list-style-type: none"> - failure to comprehensively assess her urinary incontinence since admission; - failure to complete a 3-day voiding diary since admission; - failure to implement a toileting program until 2/14/15, approximately one month after admission; - failure to monitor, implement, evaluate and/or revise approaches that were ineffective; and - failure to prevent several UTI's, two of which resulted in transfers to the hospital. <p>3. R166 was admitted to the facility on 2/23/15 with diagnoses that included dementia and a history of UTI and urosepsis.</p> <p>The Nursing Admission Assessment, dated</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 54 2/23/15, under the GU section was not completed.</p> <p>An Incontinence Assessment and Evaluation (IAE), dated 2/23/15, stated R166 was alert and oriented to person and place, had no short term memory loss, and required moderate assistance with ADLs. This evaluation was not completed in regards to R166's continence status. It failed to identify whether R166 was continent or incontinent, if a voiding diary was initiated, if there were any contributing diagnoses, and failed to identify how much assistance R166 required with ambulation, transfers and toileting assistance.</p> <p>R166's clinical record revealed that on 2/23/15 a voiding diary was started. Instructions on the voiding diary stated, "Check resident every two (2) hrs, place an X in the appropriate box. R if refuses to be toileted." The diary dates listed were 2/23/15, 2/24/15 and 2/26/15 (unclear if this was a dating error and was actually 2/25/15). Review of the voiding diary revealed it was incomplete, as there was a lack of documentation every two (2) hours as directed. In fact, on all three days there was no documentation on the 7 AM to 3 PM shift. Review of the voiding diary revealed that on 2/24/15, R166 was noted "wet" at 1:00 AM, 6:00 AM and 3:00 PM. On 2/26/15, R166 was noted "wet" at 2:00 AM, 6:00 AM, 4:00 PM and 9:00 PM. Contrary to what was documented on the voiding diary, which was completed by CNAs, the CNA ADL Flow Sheet documented R166 as always continent of bladder during the MDS assessment time period (2/24/15 through 3/2/15). The facility failed to ensure a complete voiding diary was done.</p> <p>A care plan initiated 2/23/15 for "Unable to do</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 55</p> <p>own ADLs without assistance ..." included the approach to assist resident with toileting or provide incontinence care as needed.</p> <p>A nurse's note, dated 2/26/15 and untimed, stated "... Continent of B&B c some incontinence at times ...".</p> <p>The admission MDS assessment, dated 3/2/15, stated that R166's daily decision making skills were moderately impaired, that she required limited assist of one (1) staff for transfers, and required extensive assist of one (1) staff for toilet use and hygiene. The 3/2/15 MDS assessment also stated R166 was always continent of bladder during the assessment period (2/24/15 through 3/2/15), despite evidence of incontinence noted on the voiding diary on 2/24/15 and 2/26/15, and as noted in the 2/26/16 nurse's note. The CAA triggered the care area of urinary incontinence as a potential problem area and was checked to proceed with care planning. The Care Area Assessment Summary, dated 3/2/15, stated "... B&B: cont (continent) of B&B, requests toileting on own ... Per staff interview can walk some c RW to BR ... toilets per request per staff, can help some and stand and pivot (turn) c grab bars in BR, needs help c clothes ...".</p> <p>On 3/2/15, a care plan for "Resident is continent of bowel and bladder but needs assist to toilet" was initiated. This care plan's approaches included to assist resident with transfer to toilet upon request or per toilet schedule, "able to express need to toilet, toilet upon request."</p> <p>ADL Flowsheets, completed by CNAs, from 3/1/15 through 3/31/15, documented that R166 was always continent of bladder.</p>	F 315	Please see previous page	
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F 315	<p>Continued From page 56</p> <p>Review of nurse's notes revealed the following: 3/4/15 3:45 PM - "... continent of B&B c some incontinence...". 3/3/15 4:20 AM - "... occasional incontinence noted ...". 3/3/15 3:20 PM - "... continent of B&B c occasional incontinence ...". 3/8/15 12:45 PM - "... continent of B&B c occasional incontinence ...". 3/8/15 9:00 PM - "... incontinence care provided by staff ...".</p> <p>A 3/9/15 14-Day PPS assessment stated R166 was always continent of bladder, despite documentation in nurse's notes of incontinence. There was no evidence that although there was a discrepancy between ADL Flowsheets and nurse's notes, that any further re-assessment was completed at this time.</p> <p>Review of nurse's notes revealed the following: 3/10/15 3:30 AM - "... incontinent care provided ...". 3/14/15 1:45 PM - "... incontinent noted occasional (sic) ...". 3/14/15 8:05 PM - "... incontinent care provided ...". 3/16/15 4:35 AM - "... continent of B&B c occasional incontinence ...". 3/18/15 3:45 PM - "... continent of B&B c some incontinence at times ...". 3/27/15 untimed - "... Incontinent of B&B ...".</p> <p>A 3/23/15 30-Day PPS assessment stated R166 was always continent of bladder, despite continuing discrepancies in documentation. There was no evidence the facility identified the discrepancies and no evidence that they</p>	F 315	Please see previous page	

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F 315	<p>Continued From page 57 reassessed R166.</p> <p>According to the CNA ADL Flowsheets from 4/1/15 through 4/30/15, R166 was incontinent of bladder on every single shift. Review of nurse's notes for this same time frame revealed documentation that R166 was continent despite opposing documentation on the ADL Flow Sheets.</p> <p>On 4/2/15, a UA and urine C&S was ordered by the physician due to a change in R166's mental status. On 4/4/15, R166 was started on an antibiotic for a UTI.</p> <p>A 60-Day PPS assessment, dated 4/20/15, stated R166 was frequently incontinent of bladder during the assessment review period (4/14/15 through 4/20/15).</p> <p>A significant change MDS assessment, dated 4/27/15, stated R166's daily decision making skills were intact, and that there was no trial of a toileting program attempted on admission or since urinary incontinence was noted in this facility.</p> <p>On 4/27/15, a physician's order stated, "UA, C&S...dx urinary incontinence."</p> <p>Review of the clinical record revealed a voiding diary was to be completed from 4/27/15 through 4/29/15. The voiding diary was once again incomplete.</p> <p>On 4/29/15, R166 was started on an oral antibiotic for a diagnosis of UTI. On 4/30/15, a second antibiotic was added, which required injection into a muscle twice daily.</p>	F 315	Please see previous page	
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F 315	<p>Continued From page 58</p> <p>Review of the clinical record revealed that on 5/1/15 at 3:10 AM, R166 was sent out to the hospital emergency room due to difficulty breathing. R166 did not return to this facility.</p> <p>During an interview on 7/13/15 at 11:10 AM, E14 (RNAC) confirmed she completed the MDS assessments for R166. E14 stated she reviews the CNA Flow Sheets for coding of the MDS and then she interviews staff, mainly the CNAs and UM, if there is a discrepancy in documentation. E14 stated that based on what she determined during interviews, that is what she codes. E14 confirmed the Nursing Admission assessment was incomplete under the section GU, and confirmed the Incontinence assessment and voiding diary were also incomplete and that the voiding diary noted R166 to be "wet." E14 further stated that when she completed the 60-Day PPS assessment, she noted the decline in bladder continence and went on to complete a significant change in status MDS assessment. E14 stated she remembers a discussion about this significant change as the resident became incontinent, but that R166 was sent out to the hospital shortly afterwards.</p> <p>In an interview with E13 (LPN/UM) on 7/13/15 at approximately 11:30 AM, E13 confirmed the nursing Admission assessment, Incontinence assessment, and voiding diary were all incomplete. E13 confirmed the voiding diary noted R166 as being "wet," while the same CNAs completing the diary documented this resident as being continent at those times. E13 stated it was the UM who was to review the voiding diary. E13 confirmed she had not looked at or reviewed R166's voiding diary. She stated that she tries to</p>	F 315	Please see previous page		

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F 315	Continued From page 59 toilet residents for the first few days after their admission to determine their continence status and then interviews the CNAs by asking if the resident was continent or incontinent on their shift. E13 stated that it was determined that R166 was continent based on her toileting the resident herself and through CNA interviews. In an interview on 7/13/15 at approximately 2:30 PM with E2 and E13, E2 stated that she spoke with the nurse who wrote the 2/28/15 note about R166 being incontinent. E2 stated the nurse said she answered R166's call light that night, the resident was wet and she provided incontinence care, however, the nurse never informed the CNA. E2 stated a second nurse they spoke with also stated the exact same thing, that she had provided care for the resident and had not informed the CNA that the resident was incontinent. The facility failed to accurately and comprehensively assess R166's urinary status upon admission, failed to identify this resident was at times incontinent, failed to complete a voiding diary, and failed to base on voiding patterns, develop an individualized toileting plan in an attempt to restore as much bladder function as possible and prevent UTI. R166's urinary status declined after admission to the facility and the resident developed a significant UTI requiring multiple antibiotics.	F 315	Please see previous page	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318	F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION A. The device was placed in the R41's hand and no ill effect was noted from the cited event as evidenced by no decrease in ROM or skin breakdown. Therapy staff performed ROM measurements and identified no change from the previous result. R41 is functionally within normal limits. B. All residents with B/L palmer splints or similar devices have the potential to be affected. All residents with such splints have been assessed by nursing and have them in place. C. All care giving staff will be in serviced regarding ADL care including B/L palmer splint application by Staff Development prior to September 11 th . Training will be reviewed by all care giving staff at least annually. D. UM/Supervisors will examine 2 residents on each unit (6) on each shift (3) to ensure splint is provided appropriately (22% sample) daily X 14, weekly, X 2, and monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process.(Attachment 2)	9-11-15

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F 318	<p>Continued From page 60</p> <p>appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (R41) out of 36 Stage 2 sampled residents. Findings include:</p> <p>R41 was originally admitted to the facility in 2006 with diagnoses that included persistent vegetative state and contractures of multiple joints.</p> <p>R41's July 2015 monthly POS stated, "Resident to wear B/L palmar splints for a total of 8 hours every 24 hours. Staff may remove for activities and comfort ... Rolled wash cloths to B/L hands."</p> <p>Observations of R41 revealed the following: 7/1/15 3:28 PM - B/L hand contractures, no palmar splints or rolled wash cloths in place; 7/6/15 8:32 AM - B/L hands fisted, no palmar splints or rolled washcloths in place; 7/7/15 10:51 AM - B/L hands fisted, no palmar splints or rolled washcloths in place; 7/7/15 11:51 AM - no splints or rolled washcloths in place.</p> <p>During an interview with E22 (CNA) on 7/8/15 at 11:39 AM, she stated that at times she was unable to locate R41's splints so then she would place rolled washcloths.</p>	F 318	Please see previous page	

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F 318	Continued From page 61	F 318		
F 323 SS=D	<p>Findings were confirmed during interview with E2 (DON) on 7/14/15 at approximately 10:00 AM.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and review of facility documentation and video footage, it was determined that for two (R16 and R28) out of 36 Stage 2 sampled residents, the facility failed to ensure that the residents' environment remained as free of accident hazards as was possible and residents received appropriate assistive devices to prevent accidents. The facility failed to apply leg rests to R16's wheelchair when he was transported out of the facility for an appointment. R16 was unable to consistently hold his feet up while being pushed in the wheelchair resulting in an injury to his right [R] foot. For R28, the facility failed to ensure that his bed side rails were secure. Findings include:</p> <p>1. R16 was re-admitted to the facility on 6/11/15, post hospitalization, on Hospice services with diagnoses that included diabetes mellitus, PAD, a history of B/L bypass graft surgery and history of an amputation of the left great (big) toe.</p>	<p>F 323</p> <p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES</p> <p>Ex.1 A. R16 no longer resides in the facility. R16 used his feet exclusively to ambulate in his wheel chair and refused an offer of leg rests prior to the appointment. R16's cited injury resolved completely prior to discharge. B. All residents have the potential to be affected. Residents who ambulate with their feet to self-propel a wheelchair will be encouraged to use foot rests when exiting the building. Should residents refuse, risk vs. benefit will be discussed. C. All care giving staff will be in serviced regarding transport of wheel chair occupants to include resident's rights and preference in coordination with safety by Staff Development prior to September 11th. Training will be reviewed by all care giving staff at least annually. D. UM/Supervisors will observe transport of 2 wheel chair occupying residents on each unit (6) on each shift (3) to ensure transport is provided appropriately (22% sample) daily X 14, weekly, X 2, and monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. Attachment 2)</p> <p>Ex.2 A. R28's bed was unoccupied as he was on Medicaid bed-hold on the date cited. The side rail was secured and is safely functional. Resident no longer resides in the facility. B. All residents with side rails have the potential to be affected. All side rails have been examined and are secure and functional. C. All care giving staff will be in serviced regarding reporting loose side rails by Staff Development prior to September 11th. Training will be reviewed by all care giving staff. D. UM/Supervisors will observe Side rails on 2 beds on each unit (6) on each shift (3) to ensure side rails are secure (22% sample) daily X 14, weekly, X 2, and monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2, Attachment 6)</p>	<p>9-11-15</p> <p>9-11-15</p>	

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The 6/17/15 significant change MDS assessment stated R16's cognitive skills for daily decision making were moderately impaired (decisions poor, cues/supervision required). The same MDS stated R16 had not, during the MDS review period, transferred out of bed, walked in his room and/or corridor, and had not had any locomotion (in a wheelchair) on or off the nursing unit. Review of R16's clinical record revealed he was receiving daily wound treatments to both heels.

During an interview with E5 (UM) on 7/7/15 at approximately 9:10 AM, she stated that R16 was due to go out for an appointment this morning. E5 also stated that R16 used to ambulate, at times, but has not walked "in a while, now prefers to stay in bed," and that previously he used to spend most of the day sitting up in his wheelchair.

Observation of R16 on 7/7/15 at 9:25 AM revealed him seated in a wheelchair being pushed by a transporter out of the facility for an appointment. R16's wheelchair did not have leg rests applied to it and he was wearing non-skid slipper socks on his feet.

On 7/8/15 at 8:00 AM, wound care to R16's heels was observed being completed by E26 (WCN). E26 stated to R16 that she had been told that he sustained an injury to the tip of his right great toe yesterday when he went out for his appointment. A red circular wound was observed on R16's right great toe. R16 stated that he does not recall banging it yesterday, but when he came back from his appointment he was told his foot was bleeding. Upon removing the old dressing from R16's right heel, an intact blood blister approximately the size of a half dollar was

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F 323	<p>Continued From page 63</p> <p>observed on the inner aspect of the right heel. E26 asked the resident "What happened? This wasn't here when I saw you last on Friday." E26 stated today (Wednesday) was her first day back to work since last Friday and that the blood blister was not present then. E26 stated she would speak with E27 (LPN), who had completed the wound care in her absence. R16 was not aware of any issue on his inner right heel and he denied having any pain. During observation of the wound care, R16 was observed to be barely able to hold his feet up off the bed.</p> <p>A nurse's note, dated 7/8/15 and timed 9:10 AM, a late entry for 7/7/15, stated, "During wound care on 7/7/15, noted a blood blister on R (right) heel, intact, also noted a skin tear to R great toe 1.2 x 0.9 cm. Resident does not recall/know how injury occurred ...".</p> <p>During an interview with E27 on 7/8/15 at 1:40 PM, she confirmed that she completed R16's wound care on Monday (7/6/15) and there were no issues with the R great toe or inner R heel. E27 stated that yesterday (7/7/15) she did not get to complete his wound care before his appointment, as when she got there to do it the transporter was already waiting for R16. She stated she was paged when he got back, as blood was noted on his R great toe, and it appeared to be a skin tear. E27 stated she completed all his treatments at that time and she observed the blood blister on the R inner heel, but forgot to write a note, so she wrote a late entry note about it today.</p> <p>In an interview with E28 (LPN) on 7/8/15 at 2:40 PM, she stated that since returning from the hospital in mid June, R16 has not been getting</p>	F 323	Please see previous page	
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F 323	<p>Continued From page 64</p> <p>out of bed. She stated that before being hospitalized he used to sit up in his wheelchair most of the day, watch TV in his room and propel himself slowly out of the room for activities.</p> <p>On 7/9/15 at 8:05 AM, R16 was interviewed. The resident was asked if he recalled the other day when he went out for an appointment and whether anyone offered to place leg rests on his wheelchair or if anyone asked him if he wanted them on? R16 stated that he did not know he was going out for an appointment and after he finished his breakfast it was a rush getting him ready and up because the transporter was waiting. When asked if he had difficulty holding his feet up while being pushed in his wheelchair, he stated yes, that he had noticed that on Tuesday when he went for the appointment. He further stated that he did not feel anything and then was told he was bleeding.</p> <p>On 7/9/15 at 2:10 PM, during an interview with E3 (ADON), the surveyor was shown the entry door where the facility thought R16 bumped his R great toe when returning from the appointment. E3 showed the surveyor the tip of the door that now had a rubber flap on it which was placed by maintenance after R16's injury.</p> <p>On 7/9/15 at 2:20 PM, the facility video was viewed by two (2) surveyors along with E1 (NHA) and E3. The first video, dated 7/7/15 Tue (Tuesday) 12:24:46, revealed R16 being pushed in a wheelchair through the outside door into the reception area by a transporter. R16's R foot was dragging slightly on the floor. The second video, dated 7/7/15 Tue 12:25:12, showed the second door being opened onto the nursing unit and R16 being wheeled in by the transporter. R16's R foot</p>	F 323	Please see previous page	

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was not fully visible on the video, however the resident was not holding his R leg upward and then a smear of blood was noted on the floor.

During an interview with E3 and E5 (RN/UM) on 7/14/15 at 3:45 PM, concerns regarding the lack of use of wheelchair leg rests and injuries sustained by R16 were discussed. E5 stated that a CNA asked the resident if they could put on leg rests and he had refused, stating it was his preference not to have them on, as they were cumbersome. The resident's current decline in condition, his inability to hold his legs up for a prolonged time period, his heel wounds and lack of sensation due to his clinical condition and concerns for safety and prevention of an accident hazard were discussed with E3 and E5. E3 stated she was not familiar with the resident, but understood what was being said about his safety.

The facility failed to identify a potential hazard and failed to implement use of wheelchair leg rests in order to reduce the risk of an accident for R16.

Findings were reviewed with E2 (DON) on 7/15/15 at approximately 11:00 AM.

2. An observation on 7/2/15 at 11:18 AM revealed R28's half side rails on his bed were loose.

In an observation and interview on 7/2/15 at 4:30 PM, E2 and E4 (RN/UM) confirmed that R28's bed side rails were loose. E2 stated they would replace R28's bed immediately with a bed in storage.

The facility failed to ensure that R28's environment remained as free of accident hazards as is possible when his bed side rails

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for R36. For R157, the facility failed to ensure that R157's drug regimen was free from excessive medications when incorrect dosages of an anti-psychotic medication were administered for 16 days. Findings include:

1. Review of the clinical record revealed R36 was receiving supplemental Vitamin D orally.

A pharmacy consultant's recommendation, dated 11/30/14, stated to consider obtaining blood work for a Vitamin D level since R36 was receiving supplemental Vitamin D. This recommendation was approved by the physician (undated). Review of the clinical record lacked evidence that an order was written in 12/2014 for a Vitamin D level to be drawn. Further review of physician's order sheets revealed that on 5/7/15, an order was written stating for the pharmacy to add to the monthly physician order sheets "Vitamin D Level every 6 months in June and December."

Review of R36's clinical record lacked evidence of any Vitamin D level results.

On 7/15/15 at 10:25 AM, E24 (Unit Clerk) was asked to call the laboratory to determine if any Vitamin D levels were drawn on R36. After calling the laboratory, E24 confirmed that no Vitamin D levels were drawn.

The facility failed to ensure that adequate monitoring was completed for use of Vitamin D for R36.

Findings were confirmed by E2 [DON] during an interview on 7/15/15 at approximately 11:00 AM.

2. R157 was admitted to the facility on 1/9/15 with

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F 333	<p>Continued From page 69</p> <p>by: Based on record review and interview, it was determined that for one (R157) out of 36 Stage 2 sampled residents, the facility failed to ensure that residents are free of any significant medication errors. For R157, the facility failed to discontinue a 1/9/15 order of Zyprexa, an anti-psychotic medication, when a 1/12/15 physician's order changed the dose, and the facility administered incorrect dosages of Zyprexa for 16 days. Findings include:</p> <p>R157 was admitted to the facility on 1/9/15 with diagnoses that included dementia with behaviors and psychosis.</p> <p>The physician order sheet (POS), dated 1/9/15, stated that R157 was ordered Zyprexa 1.25 mg every night for agitation/psychosis.</p> <p>A physician's order, dated 1/12/15, stated to change Zyprexa to 5 mg every night for 10 days then reduce to 2.5 mg every night for 10 days and then to stop the medication.</p> <p>Review of the January 2015 MAR revealed the following: - from 1/12/15 through 1/21/15 (10 days), R157 received Zyprexa 5 mg plus Zyprexa 1.25 mg, totaling 6.25 mg; and - from 1/22/15 through 1/27/15 (6 days), R157 received Zyprexa 2.5 mg plus Zyprexa 1.25 mg, totaling 3.75 mg.</p> <p>The facility failed to ensure R157 was free of any significant medication error when incorrect dosages of Zyprexa were administered for 16 days. Findings were confirmed on 7/15/15 at 2:40 PM with E2 (DON) and E4 (RN/UM).</p>	F 333	Please see previous page		

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F 371 SS=E	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to store food under sanitary conditions. Additionally, during the 7/1/15 meal observation, the facility failed to distribute food under sanitary conditions. Findings include:</p> <p>1. During a kitchen observation on 7/1/15 with E16 (FSD) between 7:45 AM to 9:30 AM, the following was observed: While inspecting the dry storage area at 8:26 AM, the fluorescent ceiling light above the dried foods lacked a cover. The unprotected light tubes (2) which were not shatter proof presented as a chemical contaminant in terms of mercury and a physical contaminant in terms of glass shards if they were to break. E16 confirmed the finding.</p> <p>Findings were reviewed on 7/2/15 at 4:30 PM with E1 (NHA), E2 (DON), E16, and E17 (MD).</p> <p>2. During the lunch observation in the C wing dining room on 7/1/15 at 11:37 AM, E8 (CNA) set up a tray for R145 and touched/contaminated the</p>	F 371	<p>F371 483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY Ex. 1 A. The fluorescent ceiling light cover has been replaced. B. All residents receiving meals prepared from items in the dry storage area have the potential to be affected if an uncovered light bulb breaks. C. The dry storage area lighting is now reviewed as part of maintenance rounds. Repairs will be completed as identified. D. The MD or designee will audit 100% of lighting fixtures in the dry storage area to ensure compliance. Audits will be conducted twice weekly for one quarter until 100% compliance has been observed. Lights will then be inspected at least quarterly to maintain full compliance. MD will report findings through the QAPI process. Ex. 2 A. R145 suffered no untoward effect from cited event on 7/1/15. Observation of cited event was not communicated to facility staff until 7/2/15 therefore no immediate intervention occurred. Facility staff have now been in-serviced by staff development to maintain the appropriate delivery of assistive devices during mealtime to ensure sanitary conditions. B. All residents who utilize "sippy cups" have the potential to be affected. Facility staff were reminded by nursing administration to maintain the appropriate delivery of assistive devices during mealtime to ensure sanitary conditions. C. Staff will be in serviced regarding proper hand washing and assistive device handling techniques by Staff Development prior to September 11th. Policy and procedure will be reviewed by all meal delivery staff at least annually. D. Dietary Service Director/designee will observe 66% of meal deliveries daily X 14 days, weekly X 2, and monthly X 2 and until 100% compliance has been observed. Dietary Service Director will report findings through QAPI process. (Attachment 6)</p>	9-11-15 9-11-15

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE 19808	
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F 371	Continued From page 71 mouth portions of 2 sippy cups for the resident.	F 371	F428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Ex.1 A. R36 no longer resides in the facility. Vitamin D levels were drawn on 7/15/05 and were within normal limits. B. All residents receiving Vitamin D supplements have the potential to be affected. Those residents with Vitamin D levels ordered will be reviewed for compliance by UM prior to September 11, 2015. UM will review for accuracy of order and transcription of medications. Citations will be reviewed with Pharmacy Consultant by Director of Pharmacy service prior to September 11, 2015. C. Licensed staff will be in-serviced regarding pharmacy recommendations by Staff Development prior to September 11 th and follow through on those recommendations. Training will be reviewed by all licensed nursing staff at least annually. Director of Pharmacy will in-service current Pharmacy Consultant regarding proper identification of events cited regarding Vitamin D levels prior to September 11 th . Director of Pharmacy will review training with consultant at least annually. D. DON/designee will review Monthly Pharmacy recommendations to ensure recommendations have been addressed timely and accurately monthly X 3 and until 100% compliance has been observed. Consultant Pharmacist will review recommendations monthly to ensure timely response. DON/designee and Consultant Pharmacist will report findings through QAPI process (Attachment 9).	9-11-15
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of facility documentation, it was determined that the consultant pharmacist failed to identify and report irregularities for two (R36 and R157) out of 36 Stage 2 sampled residents. Findings include: The Consultant Pharmacy's policy entitled "Medication Regimen Review (Monthly Report)", last revised on 5/21/07, stated, "... The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs); prescribers' orders; ... laboratory and diagnostic test results ... Resident-specific irregularities ... are documented in the resident's (active record) and reported to the Director of Nursing, and/or prescriber as appropriate ...".	F 428	Ex.2 A. R157 suffered no untoward effect and no longer takes anti-psychotic medication. R157's remaining medication regimen was reviewed by the physician and found to be appropriate. B. All residents taking anti-psychotic medications have the potential to be affected. Those residents prescribed antipsychotic medications will be reviewed for accuracy of order and transcription compliance by UM prior to September 11, 2015. C. Licensed staff will be in-serviced regarding accuracy of order transcription by Staff Development prior to September 11 th . Twenty-four hour chart checks will be instituted to ensure orders are accurately transcribed. 11-7 licensed staff will write "24 Hour Chart Check completed" followed by signature, time and date on the last order written for each resident. Discrepancies will be resolved upon physician notification. Training will be reviewed at least annually. Director of Pharmacy will in-service current Pharmacy Consultant regarding proper identification of antipsychotic monitoring prior to September 11 th . Director of Pharmacy will review training with consultant at least annually. D. UM/designee will review twenty-four hour chart checks to ensure compliance and accuracy daily X 1 month until 100% compliance is achieved. Discrepancies noted will be tracked to identify patterns (if any). UM/designee will report findings through QAPI process (Attachment 10).	9-11-15

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F 428

Continued From page 72

Cross refer F329, example 1
1. On 11/30/14, the consultant pharmacist made a recommendation for a Vitamin D level to be drawn, as R36 was receiving supplemental Vitamin D. R36's physician agreed with this recommendation. Review of the clinical record revealed that R36 did not have a Vitamin D level drawn.

Although the consultant pharmacist completed monthly drug regimen reviews for R36 from 12/14 through 6/15, they failed to identify and report that R36 did not have any Vitamin D levels drawn.

Findings were confirmed by E2 (DON) during an interview on 7/15/15 at approximately 11:00 AM.

2. Cross refer F329, example 2
The physician order sheet (POS), dated 1/9/15, stated that R157 was ordered an anti-psychotic medication, Zyprexa 1.25 mg every night for agitation/psychosis.

A physician's order, dated 1/12/15, stated to change Zyprexa to 5 mg every night for 10 days then reduce to 2.5 mg every night for 10 days and then to stop the medication. The 1/9/15 physician's order for Zyprexa was never discontinued.

On 1/15/15, the consultant pharmacist reviewed R157's medications and failed to identify and report that two orders of Zyprexa were currently being administered to R157.

Review of the January 2015 MAR revealed the following:
- from 1/12/15 through 1/21/15 (10 days), R157

F 428

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F 428	Continued From page 73 received Zyprexa 5 mg plus Zyprexa 1.25 mg, totaling 6.25 mg; and - from 1/22/15 through 1/27/15 (6 days), R157 received Zyprexa 2.5 mg plus Zyprexa 1.25 mg, totaling 3.75 mg. The consultant pharmacist failed to identify and report an irregularity during a monthly medication review that R157 was receiving two separate doses of an anti-psychotic medication. Findings were confirmed on 7/15/15 at 2:40 PM with E2 and E4 (RN/UM).	F 428	Please see previous page	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS A. R4 suffered no ill effect from the event cited. The offending items were removed from the area immediately. B. All residents have the potential to be affected. All rooms are monitored by the UM during day shift and the Supervisor on evening and night shift. C. All staff will be in serviced regarding infection control as it relates to this event by Staff Development prior to September 11 th . Training will be reviewed by all staff at least annually. D. UM/Supervisors will observe 2 room potential soiled linen opportunities on each unit, (6); on each shift (3); for compliance (22% sample) daily X 14, weekly X 2, monthly X 2 and until 100% compliance has been observed. UM will report findings through QAPI process. (Attachment 2)	9-11-15

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F 441	Continued From page 74 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that linens were handled in a manner to prevent the spread of infection and to prevent the transmission of disease was implemented for one (R4) resident out of 36 Stage 2 sampled. Finding include: On 7/2/15 at approximately 10:30 AM, it was observed that the staff assigned for R4's AM care left unbagged soiled linen plus other bagged linen on the floor in R4's room. This finding was witnessed by E23 (RN) and reviewed with E23 on 7/2/15 at approximately 10:30 AM.	F 441	Please see previous page	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	F502 483.75(j)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE A. R36 no longer resides in the facility. Vitamin D levels were drawn on 7/15/05 and were within normal limits. B. All residents receiving Vitamin D supplements have the potential to be affected. Those residents with Vitamin D levels ordered will be reviewed for compliance by UM prior to September 11, 2015. UM will review for accuracy of order and transcription of medications. Citations will be reviewed with Pharmacy Consultant by Director of Pharmacy service prior to September 11, 2015. C. Licensed staff will be in-serviced regarding pharmacy recommendations by Staff Development prior to September 11 th and follow through on those recommendations. Training will be reviewed by all licensed nursing staff at least annually. Director of Pharmacy will in-service current Pharmacy Consultant regarding proper identification of events cited regarding Vitamin D levels prior to September 11 th . Director of Pharmacy will review training with consultant at least annually. D. DON/designee will review Monthly Pharmacy recommendations to ensure recommendations have been addressed timely and accurately monthly X 3 and until 100% compliance has been observed. Consultant Pharmacist will review recommendations monthly to ensure timely response. DON/designee and Consultant Pharmacist will report findings through QAPI process (Attachment 9).	9-11-15

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F 502	<p>Continued From page 75</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide or obtain laboratory services to meet the needs of one (R36) out of 36 Stage 2 sampled residents. Findings include:</p> <p>Cross refer F329, example 1 A pharmacy consultant's recommendation, dated 11/30/14, stated to consider obtaining blood work for a Vitamin D level since R36 was receiving supplemental Vitamin D. This recommendation was approved by the physician. Review of the clinical record lacked evidence that an order was written in 12/2014 for a Vitamin D level to be drawn. Further review of physician's orders sheets revealed that on 5/7/15, an order was written for the pharmacy to add to the monthly physician order sheets "Vitamin D Level every 6 months in June and December."</p> <p>Review of R36's clinical record lacked evidence of any Vitamin D level results.</p> <p>On 7/15/15 at 10:25 AM, E24 (Unit Clerk) was asked to call the laboratory to determine if any Vitamin D levels were drawn on R36. After calling the laboratory, E24 confirmed there were no Vitamin D levels drawn.</p> <p>The facility failed to obtain a Vitamin D level every 6 months in December and June for R36.</p> <p>Findings were confirmed by E2 (DON) during an interview on 7/15/15 at approximately 11:00 AM.</p>	F 502	<p>Please see previous page</p>		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB</p>	F 514	<p>F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE A. R28 was readmitted on 7/22/15 with a diagnosis of Anemia of Chronic Disease, consistent with expected progression of renal disease. R28 did not experience a "GI bleed". As reported in this 2567 on page 33, R28's Hemoglobin was tracked and reported multiples times in March, April, May, and June. Per primary care physician and hospital Cardiologist R28's chest pain is "non-cardiac" and is not related to his expected anemia of chronic disease. Upon re-admission, R28's hemoglobin was obtained per physician order and results communicated upon receipt to the physician and documented in the resident record. R28 diet was also corrected at the time of readmission. R28 no longer resides in the facility. B. There are no hemodialysis residents in the facility at this time. Should any new or existing resident require hemodialysis, the corrective action developed will be implemented for that resident(s). C. Receiving Nurse, post dialysis, will communicate weekly with dialysis center for lab results. Results will be documented in resident medical record for physician review. Resident diet will be reviewed for accuracy upon return. D. UM/designee will audit (Attachment 5) lab results weekly x 4, monthly x 2 and report findings through QAPI.</p>	9-11-15	

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F 502	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide or obtain laboratory services to meet the needs of one (R36) out of 36 Stage 2 sampled residents. Findings include: Cross refer F329, example 1 A pharmacy consultant's recommendation, dated 11/30/14, stated to consider obtaining blood work for a Vitamin D level since R36 was receiving supplemental Vitamin D. This recommendation was approved by the physician. Review of the clinical record lacked evidence that an order was written in 12/2014 for a Vitamin D level to be drawn. Further review of physician's orders sheets revealed that on 5/7/15, an order was written for the pharmacy to add to the monthly physician order sheets "Vitamin D Level every 6 months in June and December." Review of R36's clinical record lacked evidence of any Vitamin D level results. On 7/15/15 at 10:25 AM, E24 (Unit Clerk) was asked to call the laboratory to determine if any Vitamin D levels were drawn on R36. After calling the laboratory, E24 confirmed there were no Vitamin D levels drawn. The facility failed to obtain a Vitamin D level every 6 months in December and June for R36. Findings were confirmed by E2 (DON) during an interview on 7/15/15 at approximately 11:00 AM.	F 502	Please see previous page	
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514	F514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE A. R28 was readmitted on 7/22/15 with a diagnosis of Anemia of Chronic Disease, consistent with expected progression of renal disease. R28 did not experience a "GI bleed". As reported in this 2567 on page 33, R28's Hemoglobin was tracked and reported multiples times in March, April, May, and June. Per primary care physician and hospital Cardiologist R28's chest pain is "non-cardiac" and is not related to his expected anemia of chronic disease. Upon re-admission, R28's hemoglobin was obtained per physician order and results communicated upon receipt to the physician and documented in the resident record. R28 diet was also corrected at the time of readmission. R28 no longer resides in the facility. B. There are no hemodialysis residents in the facility at this time. Should any new or existing resident require hemodialysis, the corrective action developed will be implemented for that resident(s). C. Receiving Nurse, post dialysis, will communicate weekly with dialysis center for lab results. Results will be documented in resident medical record for physician review. Resident diet will be reviewed for accuracy upon return. D. UM/designee will audit (Attachment 5) lab results weekly x 4, monthly x 2 and report findings through QAPI.	9-11-15

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F 514	<p>Continued From page 76 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of other documentation, it was determined that for one (R28) out of 36 Stage 2 sampled residents, the facility failed to maintain R28's clinical record in accordance with accepted professional standards and practices that are complete, accurately documented and readily accessible. Findings include:</p> <p>1a. In an interview, on 7/7/15 at 10:24 AM, E4 (RN/UM) was asked for all laboratory (lab) results from the dialysis center since March 2015. The facility immediately requested a list of all labs from the dialysis center which were received by fax on 7/7/15 at 11:55 AM.</p> <p>R28's clinical record lacked evidence of lab results from the out-patient dialysis center that were complete and readily accessible to nursing staff.</p>	F 514	Please see previous page	

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F 514	Continued From page 77 1b. In an interview on 7/15/15 at 2:10 PM, E4 stated that the following two progress notes, dated 3/27/15 and 4/8/15, were located in another resident's record and not in R28's record. 3/27/15 - A progress note, untimed, stated that R28 was seen and examined for positive heme stool and pain to his left hip and left shoulder. The note also stated that R28 lacked evidence of current active bleeding. However, the note stated to send R28 to the ER for further evaluation of left hip pain, left shoulder pain and anemia. 4/8/15 - A progress note, untimed, stated that "... recent (+) heme stools. No obvious bleeding currently ... Hgb 10.8 on 3/23 ... (1) Hemoccult stool - stable for now will reconsult GI for further workup if hemoglobin is > (sic) 8.0 ...". 1c. R28 was ordered a mechanical soft texture diet for June 2015 and July 2015. The facility's Resident Care Profile for R28 that was used by nursing staff incorrectly listed a regular diet for June and July 2015. The facility failed to maintain a complete, accurately documented and readily accessible clinical record for R28. Findings confirmed with E4 on 7/15/15 at 2:10 PM.	F 514	Please see previous page	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	FS20 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Ex. 1 A. R45 no longer resides in the facility and had been discharged 5/20/15 prior to survey and identification of the deficiency; therefore it could not be corrected. B. All residents have the potential to be affected. Voiding Diaries will be completed on all residents to identify potential for improving or maintaining continence per revised Incontinence policy and MDS validity which includes at least quarterly, annually, upon admission and re-admission. QA committee will be informed of findings. C. Incontinence policy has been revised (Attachments 3a through 3e). The comprehensive assessment (3b) is completed upon admission, re-admission, and quarterly and with any significant change to accurately identify those residents who are incontinent or who have a decline in continence. 100% of residents will have a comprehensive incontinence assessment as of compliance date, then per facility policy. Care plan will reflect continence status and toileting program (if any). All nursing staff will be in-serviced to ensure proper implementation by Staff Development by September 11 th . The incontinence policy will be reviewed annually by all nursing staff. D. UM/designee will review continence assessments, programs (as indicated) and ADL flow sheets to identify changes in continence patterns (if any). Findings will be reviewed with the IDT and documented at least weekly through the "High Risk" meeting. DON/designee will report results quarterly at the QAPI meeting until 6 consecutive months of 100% compliance is achieved. The incontinence assessment review will always be part of the weekly "High Risk" meeting.	9-11-15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2015
NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 GREENBANK ROAD WILMINGTON, DE 19808		
(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 520	<p>Continued From page 79 met at least quarterly to identify quality deficiencies to ensure that care practices were consistently applied.</p> <p>The facility failed, however, to ensure that appropriate treatment and services to restore and/or maintain bladder function for three residents (R45, R157 and R166) were implemented. Specifically, the facility failed to comprehensively assess all three residents' urinary incontinence; failed to complete voiding diaries; failed to individualize toileting plans; and failed to prevent UTIs, resulting in the decline of their urinary continence.</p> <p>E6 confirmed that the facility's QAA committee failed to identify, develop and implement appropriate plans of action to correct these identified quality deficiencies to ensure that care practices were consistently applied to maintain as much normal bladder function as possible and prevent UTIs.</p> <p>Findings were reviewed on 7/15/15 at approximately 4:45 PM with E1 (NHA) and E2 (DON).</p>	F 520	Please see previous page		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing and Rehabilitation Center DATE SURVEY COMPLETED: July 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from July 1, 2015 through July 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records, review of facility documentation/video and other documentation as indicated. The facility census the first day of the survey was 159. The Stage 2 survey sample size was 36.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 15, 2015, F202, F241, F253, F256, F272, F280, F281, F309, F312, F314, F315, F318, F323, F329, F333, F371, F428, F441, F502, F514 and F520.</p>	<p>Disclaimer Statement: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State laws.</p> <p>Please refer to the POC on the 2567-L survey report date ending 07/15/2015 for F202, F241, F253, F256, F272, F280, F281, F309, F312, F314, F315, F318, F323, F329, F333, F371, F428, F441, F502, F514 and F520.</p>	<p>9-11-15</p>

Provider's Signature

Title

ADMINISTRATOR

Date

9/11/2015