

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

PRINTED: 03/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

085039

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

03/11/2015

NAME OF PROVIDER OR SUPPLIER

ARBORS AT NEW CASTLE

STREET ADDRESS, CITY, STATE, ZIP CODE

32 BUENA VISTA DRIVE
NEW CASTLE, DE 19720

(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 000

INITIAL COMMENTS

F 000

An unannounced annual and complaint visit survey was conducted at this facility from February 26, 2015 through March 11, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The Stage 2 survey sample size was 33.

Abbreviations used in this report are as follows:

NHA - Nursing Home Administrator;
DON - Director of Nursing;
RN - Registered Nurse;
RD - Registered Dietitian;
LPN - Licensed Practical Nurse;
CNA - Certified Nurse's Aide;
UM - Unit Manager;
SW - Social Worker;
MD - Medical Doctor;
FSD - Food Service Director;
MDS - Minimum Data Set (standardized assessment forms used in nursing homes);
POS - Physician Order Sheet;
MAR - Medication Administration Record;
TAR - Treatment Administration Record;
Recapitulation (Recap) - monthly facility review of the POS, MAR and TAR to ensure completeness and accuracy before the orders are signed by the resident's physician;
MRR - Medication Regimen Review;
mg - milligrams, A unit of weight;
ml - milliliters, A unit of liquid volume or capacity in the metric system, 5 ml equals 1 teaspoon;
PEG tube - Percutaneous Endoscopic Gastrostomy, a tube is passed into a patient's stomach through the abdominal wall, most

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

04/24/15

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 commonly to provide a means of feeding when oral intake is not adequate; F - degrees in Fahrenheit; EMR - Electronic Medical Record; Diuretics - medicines that help reduce the amount of water/excess fluid in the body; Antidepressant - Drug to treat depression; TD - Tardive Dyskinesia - characterized by repetitive, involuntary, purposeless movements. Examples include grimacing, tongue movements, lip smacking, lip puckering, pursing of the lips and excessive eye blinking; Continence - control of bladder and bowel function; Discus Form - Assessment used to detect tardive dyskinesia (TD) and to follow the severity of patient's TD over time; Antipsychotic (medication)- used to treat psychosis and other mental and emotional conditions; Depression -mental disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Delusions - a belief held with strong conviction despite evidence to the contrary; Hallucinations - something that seems real but does not really exist; Incontinence - loss of control of bladder &/or bowel function; Stress incontinence - occurs when bladder leaks urine during physical activity or exertion; Mixed incontinence- combination of stress and urge incontinence, it shares symptoms of both; Urinary urgency - sudden, strong urge to urinate, along with bladder discomfort; Prompted void- technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule;	F 000		

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F 000	Continued From page 2 Timed toileting program - fixed time interval toileting assistance for resident's with urinary incontinence; Occasionally incontinent- less than 7 episodes of incontinence in a 7 day lookback period; Frequently incontinent -7 or more episodes of incontinence, but at least 1 episode of continent voiding in a 7 day look back period; Mania - mental illness marked by periods of great excitement, euphoria, delusions, and overactivity; Schizophrenia - mental disorder with false beliefs of being harmed; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behavior.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve a resident's concern for one (R204) out of 33 Stage 2 sampled residents. Findings include: The "Facility Resource Guide", a handbook given to all residents on admission indicated in the "Resident Concerns" section that if a resident has a concern they should, "Please complete a concern form, or have a team member complete	F 166	F0166- RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (S/S=D) A. R204 no longer resides at the facility. B. The facility policy is that concern reports are generated in the first 24 hours. E12 will be re-educated on the facility policy. C. A root cause analysis was completed and it was determined that this was an isolated occurrence. The facility QPI committee generated a QAPI for missing items which will be continued until the goal is met. The staff will be re-educated on the facility grievance policy. D. Social work director will audit 5 grievance reports weekly for appropriate follow up with the goal of 100% compliance, then 5 grievance reports monthly for two months with the goal of 100% compliance. All findings and results from the QAPI will be reported to the QPI Committee for review of compliance and progress.	04/28/15

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F 166	<p>Continued From page 3</p> <p>one for you. Concern Forms are available throughout our center. The administrator will review the form and then request the applicable department head to address the issue".</p> <p>The facility policy entitled, "Resident and Family Concerns", last updated January 2014, stated, "Any employee may receive a concern. All employees that receive a concern should attempt to resolve the concern. All employees will complete the Resident Concern report for any and all concerns".</p> <p>On 11/10/14, the Resident Council meeting minutes documented the following concern, "...Due to the number of missing items/concerns on the rise again. The council would like to invite a member of Social Services to each council meeting to a 'Missing Items' position of the meeting".</p> <p>11/24/14- The Facility Quality Performance Improvement (QPI) team initiated a "Missing Items" target with the goal to reduce overall complaints of residents' missing personal items. The facility QPI team determined there to be a trend after completing an internal survey. Root Cause Analysis for missing items included the following:</p> <ul style="list-style-type: none"> - Incomplete Inventory; -Linen not properly labeled; -Laundry not properly sorted and returned properly; -NHA and or designee need to replace or provide specific resolution; -Interdisciplinary team not diligent with documenting concerns. <p>On 2/4/15, R204 was readmitted to the facility</p>	F 166			

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F 166	<p>Continued From page 4 from a short hospital stay to room 608 B.</p> <p>On 2/12/15, R204 was transferred to room 205, a private room.</p> <p>During an interview on 3/3/2015 at 9:43 AM with R204, the resident disclosed having had missing personal items when moved from the previous room to the current room, about 3-4 weeks ago. R204 stated the missing item was reported to the "Head of Housekeeping" (E12). R204 further described her discussion with E12 stating she "Did not feel he followed through" and was not told if anyone was looking for the missing items, stating, "He didn't know anything about it and he did not seem concerned enough to look into it."</p> <p>On 3/4/15, a "Resident Concern Report" was initiated by E11 (SW) following the surveyor inquiry into whether the facility was aware of R204's concerns. The Concern report stated, "Following re-admission to the facility, R204 was placed in a new room. In the new room R204 noticed a missing item, and reported it to housekeeping. the facility will if possible purchase a new plant."</p> <p>During an interview, on 3/4/15 at 2:52 PM, E12 stated he looked for R204's missing item, but did not document or report back to the resident. E12 confirmed that he did not report R204's missing item to the Social Work department, falling to follow facility policy.</p> <p>During an interview, on 3/9/15 at 3:04 PM, E11 confirmed that there was no existing evidence that R204's concern had been addressed. E11 indicated that R204's missing item was presently being addressed as a newly reported concern.</p>	F 166		

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F 166	Continued From page 5	F 166		
F 241 SS=D	The facility failed to resolve R204's grievance related to her missing personal belonging. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations it was determined that the facility failed to promote dignity for one (R80) out of 33 Stage 2 sampled residents. Findings include: 1. During a lunch observation on 2/26/15 at 12:00 PM, E7 (LPN) was observed feeding R80 while standing up, adjacent to the bed. 2. During a lunch observation on 2/26/15 at 12:10 PM, E13 (CNA) was observed feeding R80 while standing up, adjacent to the bed. Findings were reviewed with E2 (DON) during the informational meeting on 3/11/15 at approximately 4:40 PM.	F 241	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY (S/S=D)	04/28/15
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 6 This REQUIREMENT Is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure housekeeping and maintenance services maintained a sanitary and comfortable interior. Findings include: During the environmental tour with E15 (Maintenance Director) and E12 (Housekeeping Director) on 3/10/15 at approximately 11:00 AM the following was observed: 1. Rooms 208 and 310 had a urine odor. No residents were present in the room. E12 did not have evidence of when the last thorough cleaning of either room had been completed. 2. Wallboard damage was noted in rooms 101, 102, 103, 105, 108, 202, 310, 407 and 408. 3. An unlabeled and unbagged drainage collection device was left on the back of the toilet in room 501. 4. A used fluid bag was left on the floor of room 205. 5. A incentive spirometer (respiratory device), urinal, cups and a water jug were sitting on the floor of room 404A. Findings were reviewed with E2 (DON) during the informational meeting on 3/11/15 at approximately 4:40 PM.	F 253	F0253- HOUSEKEEPING AND MAINTENANCE SERVICES (S/S=D) A. Rooms 208 and 310 have been deeply cleaned. Wallboard damage in rooms 101, 102, 103, 105, 108, 202, 310, 407, and 408 has been repaired. The unlabeled drainage collection device has been removed. The fluid bag in room 205 has been removed and room 404 has been deeply cleaned and all items removed from the floor. B. Root cause analysis was conducted and it was determined that the deep cleaning schedule was not being utilized appropriately. A facility wide audit will be completed by the maintenance and housekeeping directors to review for overall cleanliness, odors, paint damage, and items that are unlabeled and/or on the floor inappropriately. C. Maintenance and housekeeping directors will do weekly audits of all resident rooms for 30 days to review for overall cleanliness, odors, paint damage, and items that are unlabeled and/or on the floor inappropriately with the goal of 100% compliance. D. If the weekly audits are 100% compliant the Maintenance director and housekeeping director will do 10 room audits monthly for two months with the goal of 100% compliance. All results will be reported to the facility QPI Committee for review.	04/28/15
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 7 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to follow standards of practice for recap (recapitulation) of the monthly doctor's orders for four (R14, R22, R68 and R140) out of 33 Stage 2 sampled residents. The facility's system of doing monthly recaps of physician's orders was incomplete, inaccurate and ineffective in preventing errors. Findings include: The facility's policy and procedure entitled, "4.6 Recapitulation of Computerized Pharmacy Record", last revised on 5/1/10, stated, "Where Pharmacy is contractually obligated under the Pharmacy Services Agreement to provide recapitulation of computerized Pharmacy medical records: 1.1 Medical record may include... POSs, MARS, TARs... 1.2 Computerized medical records produced by Pharmacy will be delivered to Facility on a mutually agreed date every month... 3. Correction, additions, and changes to the computerized medical record should be made by a licensed nurse, Facility medical record staff or an authorized designee. The original order date should accompany written entries to the computerized medical record. Changes... should be made on the POS and the appropriate Medication Record Form when such documentation is required. Facility staff members who make hand-written changes to the POS should sign and date all entries. Once the written corrections are made... Facility should maintain any further changes in Physician/Prescriber	F 281	F0281-SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (S/S=E) A. R14 had tube feeding dosage corrected on current POS. R22 had medications clarified and added to current POS. R68 had medication discharged when error was found. R140 had diagnosis changed appropriately for psych medications. B. A root cause analysis was completed and a trend was revealed for short term residents and the accuracy of the recap procedure, therefore, a re-education will be completed for all licensed nursing staff to ensure accuracy of the monthly recaps which are completed by the end of each month with the goal of 100% compliance. C. The DON or designee will be responsible for conducting and audit of all short term residents for the current months POS for two months. D. If the short term resident audits are 100% compliance, the DON or designee will conduct audits of 5 short term residents per month for two months with the goal of 100% compliance. All results will be reported to the QPI Committee for review.	04/28/15

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F 281	<p>Continued From page 8</p> <p>orders in... current medication record and the computerized medical record until the first day of the new month. On the first day of the month... Facility should place the new computerized medical record in the resident's... medical record. On the first business day of the month... Facility should return the corrected copy of the computerized POS to the Pharmacy for immediate correction in the Pharmacy's medical records computer system. Written changes, corrections and additions may be made to the medical record until the time it is signed by the attending physician..."</p> <p>1. R22 had diagnoses of depression and anxiety (nervousness, fear, apprehension and/or worrying).</p> <p>R22's physician ordered an increase to the antidepressant medication, Remeron, on 1/9/15 from 7.5 mg to 15 mg at bedtime. On 1/16/15, R22's physician ordered the anti-anxiety medication, Valium 5 mg three times a day.</p> <p>R22's 2/15 POS lacked orders for Remeron 15 mg at bedtime and Valium 5 mg three times a day. The 2/15 POS had the Remeron order of 7.5 mg with "D/C" (discontinued) handwritten next to it, but there was no date and signature.</p> <p>When the recap was done on 1/31/15, the facility failed to identify and add the increase in Remeron and Valium to R22's 2/15 POS.</p> <p>In an interview, on 3/3/15 at 12:15 PM, E4 (UM) stated that neither medication was on R22's 2/15 POS and she did not know why these medications were not handwritten onto the POS when the recap was done and signed by the</p>	F 281			

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F 281	<p>Continued From page 9 nurse on 1/31/15.</p> <p>In an interview, on 3/9/15 at 7:45 AM, E2 (DON) stated that R22's 2/15 POS should have had Remeron and Valium added to it when the recap was done on 1/31/15, confirming the findings.</p> <p>The facility failed to follow standards of practice and the facility policy for the recap of orders for R22's 2/15 POS to ensure that the orders were complete and accurate.</p> <p>2. R14 had a PEG tube for nutrition.</p> <p>On 1/23/15, R14's physician increased R14's tube feeding formula of "Jevity 1.5" from 45 ml/hr (milliliters per hour) to 50 ml/hr, up at 12 PM and down at 6 AM.</p> <p>R14's 2/15 POS was signed 1/23/15, the same day R14's tube feeding order was increased.</p> <p>R14's 3/15 POS which had a recap done on 2/25/15, failed to reflect the current order of "Jevity 1.5" at 50 ml/hour.</p> <p>In an interview, on 3/9/15 at 8 AM, after reviewing R14's orders, E2 stated that the increased "Jevity 1.5" order should have been picked up when the recap of March orders was done on 2/25/15 to reflect 50 ml/hr not 45 ml/hr.</p> <p>The facility failed to follow the standard of practice and facility policy in doing monthly recaps of R14's physician orders to ensure that the orders were accurate. On 3/9/15 at 8 AM, E2 confirmed the findings.</p> <p>3. R68's physician discontinued Heparin, an</p>	F 281		

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F 281	<p>Continued From page 10</p> <p>anticoagulant (anti-clotting) medication, given by injection every eight hours on 2/18/15.</p> <p>R68's 3/15 POS which had a recap done on 2/26/15, failed to identify that Heparin was discontinued and the medication incorrectly remained on both the 3/15 POS and MAR. R68 was incorrectly administered 5 doses of heparin without a physician's order.</p> <p>In an interview, on 3/11/15 at 1:06 PM, E3 (ADON) stated that R68's Heparin was not identified as discontinued when the recap was done on 2/26/15 for R68's 3/15 orders.</p> <p>The facility failed to follow the standard of practice and facility policy in doing monthly recaps of R68's physician orders to ensure that the orders were accurate when Heparin was discontinued on 2/18/15, but remained on the 3/15 POS. On 3/11/15, at 1:06 PM, E3 confirmed the findings.</p> <p>4. R140 had a physician's order, dated 12/26/14, to add a diagnosis of delusion disorder for the use of Risperdal (antipsychotic medication).</p> <p>Review of R140's January 2015 POS correctly listed delusions as the diagnosis for which Risperdal was given. Review of R140's February and March 2015 POS, however, incorrectly listed that Risperdal was given for insomnia (an inappropriate indication for use) rather than delusions. A diagnosis of insomnia was incorrectly written for Risperdal during the February recap and when the March recap was done, the insomnia diagnosis continued to be incorrectly carried over.</p>	F 281		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2015
NAME OF PROVIDER OR SUPPLIER ARBORS AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720	
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F 281	Continued From page 11 Findings were reviewed with E2 during the informational meeting on 3/11/15 at approximately 4:40 PM. The facility failed to provide services that meet professional standards of quality related to recaps of physician orders.	F 281		
F 315 SS=D	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 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Interview it was determined that the facility failed to ensure that one (R137) out of 33 Stage 2 sampled residents received treatment and services to maintain or restore bladder function. Findings include: The facility's policy for Management of Urinary Incontinence stated that Extencicare Health Services Inc. required centers to identify pattern and frequency for residents with suspected or known urinary incontinence. Complete a Three-Day Elimination tracking to help determine pattern of Incontinence using the EMR. Complete	F 315	F315-NO CATHETER, PREVENT UTI, RESTORE BLADDER (S/S=D) A. R137 3 day assessment has been completed and documented appropriately. The appropriate care plan and assessments are in the chart. B. A root cause analysis was conducted and it was determined that the nurse failed to complete the bladder assessment and care plan after the completion of the 3 day notification on the electronic tracking system. All nursing staff will be re-educated on the 3 day bowel and bladder elimination program. DON or designee will be responsible for conducting audits on all residents to ensure that all residents who require it will have the appropriate bowel and bladder assessments and care plans with the goal of 100% compliance. C. The DON or designee will be responsible for printing and reviewing the increased incontinence list daily and will review with the interdisciplinary team. D. The DON or designee will audit 5 patients per week for two weeks with the goal of 100% compliance, then 5 residents per month for two months with the goal of 100% compliance. All results of the audits will be reported to the QPI committee for review.	03/20/15

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F 315	<p>Continued From page 12</p> <p>a comprehensive bladder assessment using Bladder Data Collection and Assessment and initiate Alteration in Urinary Incontinence Care Plan to manage urinary incontinence.</p> <p>R137 was admitted to the facility on 10/3/14. The admission MDS, dated 10/10/14, indicated the resident was continent of urine.</p> <p>A Resident Lifting, Transferring and Repositioning Data Collection tool, dated 10/3/14, documented the resident needed supervision/limited assistance, was full weight bearing and required the assistance of one person with transfers. This form was updated on 12/27/14 and contained the notation "no changes".</p> <p>Review of the clinical record documented that R137 started to decline in function and abilities.</p> <p>Review of MD progress notes summarized these changes: 10/28/14 worsening ataxia (loss of muscle control during voluntary movements); 10/31/14 worsening ataxia suspect renal (kidney) failure; 12/5/14 swallowing issues, not walking anymore; 12/11/14 plan for brain MRI (technique using a magnetic field and radio waves to create detailed images of organs and tissues within body); 12/22/14 weakened upper extremities; 12/23/14 myelopathy (nervous system disorder that affects the spinal cord); 12/29/14 myelopathy with (spinal) cord compression (abnormal amount of pressure on the spinal cord).</p> <p>The Care Delivery Guide (used by aide staff</p>	F 315		

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F 315	<p>Continued From page 13</p> <p>which provides giver care instructions), updated 12/27/14 from origination on 10/3/14, documented under bladder- Incontinent of bladder and (uses) bathroom.</p> <p>A quarterly MDS, dated 12/30/14, documented that R137 was now frequently incontinent of urine.</p> <p>The Bladder Data Collection and Assessment, dated 12/28/14, incorrectly documented that R137 was not incontinent in the last 7 days, was occasionally incontinent, clothes wet, new onset, stress or mixed incontinence and urine leakage on way to bathroom. Due to the incorrect documentation that R137 was continent, facility staff were not triggered to do a 3 day voiding assessment.</p> <p>The Alteration in Urinary Continence Care Plan, initiated on 1/13/15, did not Indicate continence status under the problem. Interventions included to complete a Bladder Data Collection and Assessment, provide adult briefs and toilet resident upon request.</p> <p>A Resident Lifting, Transferring and Repositioning Data Collection tool, dated 2/21/15, documented total dependence, full weight bearing, and one person extensive assist with transfer.</p> <p>Nursing Comprehensive Admission Data Collection and Assessment, dated 2/21/15, documented the resident was incontinent of urine, used briefs, was to be straight cathed (remove urine with tube) if no urine and had urgency.</p> <p>The Bladder Data Collection and Assessment, dated 2/21/15, incorrectly documented that the</p>	F 315			

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F 315	<p>Continued From page 14</p> <p>resident had not been incontinent in the last 7 days, was occasionally incontinent, clothes wet, new onset, and stress or mixed incontinence. Due to the incorrect documentation that R137 was continent, facility staff were again not triggered to do a 3 day voiding assessment.</p> <p>Review of the Comprehensive Care Plan Review Summary, dated 2/21/15, documented the following interventions were checked as completed: Alteration in Urinary Incontinence Plan of Care reviewed and updated, Bladder Data Collection and Assessment reviewed and updated, change in bladder status since last review, and care plan reviewed and updated.</p> <p>The Alteration in Urinary Continence Care Plan dated 2/21/15 documented the resident as frequently incontinent. Interventions included to provide adult briefs and change soiled clothes as needed.</p> <p>There was no evidence in the clinical record that a thorough assessment of R137's change in urinary continence was done. There was no evidence that any type of toileting program or prompted voiding had been attempted to increase bladder function, keep skin dry and promote dignity.</p> <p>The Care Delivery Guide, dated 2/21/15, was blank in the area of bladder and bowel providing no instruction to direct care staff on how to meet the resident's needs.</p> <p>An interview on 3/4/15 at 1:50 PM with R137 revealed that he was able to go to the bathroom on his own when he first came to the facility. Now he was not able to use his hands and legs as well</p>	F 315		

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F 315	<p>Continued From page 15</p> <p>and he wears a dlapser. R137 stated he is able to use a urinal and bedpan with staff assistance, but at times staff do not get to him in time and he goes in the diaper.</p> <p>An Interview on 3/4/15 at 1:58 PM with E14 (CNA) revealed that previously R137 would ask to go to the toilet and staff would take him, but now he cannot stand at the toilet. His legs get all crossed or he leans forward. He will at times ask for the bed pan or urinal, but sometimes when we get there he is already wet. For example, when he comes back from the dining room, I will meet him down at his room and often he has already gone, sometimes he knows he has gone and other times he does not. He can stand long enough to transfer into the bed or wheelchair. When asked why he couldn't transfer to the toilet, she answered that he would lean forward on the toilet due to his spinal problem.</p> <p>An Interview on 3/4/15 at 2:13 PM with E8 (LPN), revealed; the resident has an order to be straight cathed every shift due to a problem with voiding. He barely even tells you that he has to go. He is not on a voiding schedule, he is on a check and change. Since he is in an assisted dining they change him before he gets up for meals. She has not known him to use a urinal she would have to ask the aides. She believes he is a check and change.</p> <p>An Interview on 3/4/15 2:37 PM with E17 (RN) revealed that therapy determined that R137 was unsafe to transfer to the toilet anymore. He can transfer with assistance to bed. He can use the urinal and the bed pan and will ask for them. Occasionally, R137 goes in his brief. R137 knows and verbalizes when he has to go, but doesn't</p>	F 315			

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F 315	Continued From page 16 always tell staff right away. He is in the fall companion group so there is always staff with him, he can ask if he needs to urinate. R137 is not on a scheduled or timed toileting program, but has some bladder control. An interview on 3/10/15 10:44 AM with E4, (UM) revealed that R137 knows when he has to use the bathroom, but needs assistance to go. She could not explain why the 3 day assessment was not done when R137 developed a decline in continence. After multiple interviews with staff there was no explanation why a comprehensive assessment of R137's change in bladder continence was not conducted and why an individualized plan of care to maintain or restore bladder function had not been put in place.	F 315		
F 325 SS=E	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 325	F0325-MAINTAIN NUTRITION STATUS UNLESS AVOIDABLE (S/S=E) A. RD has completed the assessment for R18 and R136 and appropriate interventions have been initiated. B. Root cause analysis revealed that the RD was a temporary employee who failed to follow the facility policy. Full time dietitian is back from leave. RD will conduct an audit of all residents to ensure that assessments are current and interventions in place. C. RD will be responsible for conducting audits of 5 assessments per week for 30 days with the goal of 100% compliance. D. If the weekly assessment audits are 100% compliant, the RD will audit 5 assessments per month for two months with the goal of 100% compliance. All results will be reported and reviewed by facility QPI Committee.	04/28/15

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F 325	Continued From page 17 interview It was determined that the facility failed to identify, evaluate and address the needs of two (R18 and R136) out of 33 Stage 2 residents that experienced impaired nutrition based on body weight. The facility failed to evaluate and address the nutritional needs for R18 when she experienced severe weight losses In November 2014 over a greater than three week period. The facility failed to perform a complete quarterly nutrition assessment for R136 in December 2014 and they failed to identify a downward trend in R136's weights (wts.) since February 2015. Despite decreases in R136's weights since February, R136 failed to have a complete nutritional assessment for 6 months. Additionally, the facility had an ineffective system for tracking resident weights, doing accurate weights and reweights as needed. These practices led to the EMR system which was put in place failing to trigger significant/severe weight losses. Findings include: When asked for the facility's weight loss policy E10 (RD) provided a procedure entitled, "Unintended Weight Variance" (Nutrition Services Practice manual; last revised July 2010) that stated, "To provide the resident with adequate nutrition intervention for prevention and treatment of weight change: Identify risk factors associated with unintended weight loss upon admission/readmission and change of condition which may include, but are not limited to: ... Infection... Diarrhea... dluretic (to remove excess body fluid)... Document effectiveness of interventions in Progress Notes. Review and revise Interventions on Nutrition Care Plan... Clinical Algorithm (a step-by-step procedure for solving a problem) To Manage Unintended Weight Loss... Begin Interventions... Review in 1	F 325		

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F 325	<p>Continued From page 18</p> <p>month (or before if clinically necessary)... Weight Status- verify accuracy... Continued weight loss > (greater than) 5% in 30 days... Begin new intervention...".</p> <p>1. R18 was admitted to the facility on 10/30/14 for short term rehabilitation with diagnoses including severe c.diff (Clostridium Difficile - bacterial overgrowth that releases toxins that attack the lining of the intestines causing a contagious bowel infection) and episodes of bleeding from the intestines. C. diff is characterized by frequent watery diarrhea, abdominal pain, loss of appetite and weight loss. R18 was in the hospital for 5 weeks prior to admission to the facility.</p> <p>R18 had a Nutrition Risk Data Collection and Assessment completed by E10 (RD) on 11/3/14. R18's current weight was listed at 130 pounds (#). E10 placed R18 on a mechanically altered diet for easier swallowing and started MedPlus (high calorie, high protein nutritional supplement) 60 ml twice a day. R18's usual body weight was not listed.</p> <p>The facility developed a care plan for nutrition risk on 11/3/14. One of the goals listed in the care plan on 11/3/14 was for R18's wt. to remain stable at +/- 3% of 130# (126.1- 133.9#).</p> <p>Review of R18's admission MDS assessment, dated 11/6/14, listed a weight of 130#. No/unknown was checked for weight loss.</p> <p>R18's weights and MDS assessments after admission were as follows:</p> <p>11/11/14 - 114.2# (12.15% wt. loss in < [less</p>	F 325		

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F 325	<p>Continued From page 19</p> <p>than] 2 weeks - severe wt. loss); 11/13/14 - 120# (7.69% severe wt. loss in 2 weeks)- 14 day MDS triggered for wt. loss with wt. 120# and not on a physician-prescribed wt. loss regimen; 11/18/14 - 114.4# (12% severe wt. loss in 3 weeks); 11/28/14 - 117# (10% in 1 month- severe wt. loss) - 30 day MDS triggered for wt. loss with wt. 117# and not on a physician-prescribed wt. loss regimen.</p> <p>Record review revealed that R18 experienced a recurrence of c.diff (tested positive on 11/15/14) in the facility and she received an antibiotic for 2 weeks to treat the infection.</p> <p>Although R18 experienced severe wt. loss in November (also triggered on the MDS) and had a recurrence of c. diff which is known to cause diarrhea and weight loss, there was no evidence that R18 was reevaluated by E10. There were no RD notes written from 11/3/14 until 12/3/14. Additionally, wts. were very difficult and time consuming to track and at times were inaccurate. For example, R18's wt. on 11/28/14 was 117#, on 12/16/14 it was 174# (57# increase), and on 12/25/14 it was 120.6#. Despite a 57# increase on 12/16/14, a reweight (to determine accuracy of the weight) was not done.</p> <p>Meal intakes were reviewed from 10/31/14 to 1/28/15. Meal intakes were variable with intake being the best usually for dinner. Handwritten on the side of the meal intakes by E10 was "wt loss noted in December report- increased 60 ml medplus [dietary supplement] bid (twice a day) to 90 ml tid (3 times a day)."</p>	F 325			

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F 325	<p>Continued From page 20</p> <p>On 12/3/14, a physician's order was written to increase R18's nutritional supplement MedPlus 2.0 to 90 ml by mouth 3 times a day. There were no written wt. loss interventions ordered from 11/3/14 until 12/3/14.</p> <p>R18 was discharged from the facility on 1/28/15 with a wt. of 116#.</p> <p>E10 was interviewed on 3/10/15 at 10:41 AM. E10 stated that she works full-time in the facility and she was responsible for reviewing resident weights and determining when reweights needed to be done. E10 stated when she identifies a significant weight change of 3% in 1 week, 5% in 1 month, 7.5% in 3 months or 10% in 6 months, she notifies facility staff and the IDT (interdisciplinary team- includes nursing). E10 stated if she determines a significant change in weight, she writes a note in the resident's chart.</p> <p>E10 was interviewed again on 3/11/15 at 8:50 AM and findings were reviewed. E10 confirmed that weights were difficult to track and stated that weights were entered into the EMR and the TAR by hall nurses. E10 confirmed that weights were sometimes inaccurate and lacked reweights. E10 stated the EMR system was set up to trigger significant wt. losses/gains, but without consistent entry and accuracy of weights, the system can't work as designed. E10 stated that she reviews reports to analyze data for triggered wts. E10 confirmed that she only completed an admission assessment on 11/3/14 for R18 and did no further assessments until 12/3/14. E10 stated, "if nothing's written it wasn't done."</p> <p>The facility failed to evaluate and address the nutritional needs for R18 when she experienced</p>	F 325			

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F 325	<p>Continued From page 21 severe weight loss in November 2014.</p> <p>2. R136, a long term care resident, was admited to the facility a few years ago.</p> <p>A Nutrition Risk Data Collection and Assessment, dated 9/23/14, listed R136's wt. as 186#. He received large portions of a mechanically altered diet, got proteln supplements to enhance wound healing and snacks 3 times a day. R136's wts. were stable for the past 6 months.</p> <p>R136's annual MDS assessment, dated 12/16/14, stated the resident had severe thinking, memory impairment, he was 5'6" and weighed 192#. Medications included an antibiotic, antidepressant and diuretic. Weight loss was no/unknown and he required 1 person extensive assistance to eat.</p> <p>Review of R136's wts. were as follows: 1/2/15- 192.8#; 2/3/15- 183.2# (4.97% from 1/2/15); 3/1/15- 181.3# (5.96% in 2 months).</p> <p>Although R136's wt. trend has been steadily declining since 2/3/15, the facillity failed to do a full nutritional assessment since 9/23/14. Record review revealed a partial nutritional assessment with no notes on 12/16/14.</p> <p>Observations revealed that R136 was fed lunch by a family member on 3/4/15 and 3/9/15. R136 was fed breakfast by facility staff on 3/10/15 and he ate well.</p> <p>Findings were reviewed with E10 (RD) during an interview on 3/11/15 at 8:50 AM. E10 stated the 12/16/14 partial assessment was done by a prn (as needed) RD that filled in while she was on</p>	F 325			

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F 325	Continued From page 22 leave from 12/3/14 to 1/8/15. E10 stated she has had to redo what the prn RD did during E10's absence and that she had not gotten to R136's record yet. E10 confirmed that with R136's downward trend in weights since February, he needs to be reevaluated as his last full evaluation was 9/23/14, nearly 6 months ago. The facility failed to perform a complete quarterly nutrition assessment for R136 in December 2014 and they failed to identify a downward trend in R136's wts. since February 2015. Despite decreases in R136's weights since February 2015, R136 failed to have a complete nutritional assessment since September 2014, 6 months earlier.	F 325	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (S/S=E)	01/28/15
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	A. R11, R68, and R140 will have the baseline discuss completed. For R108 the order cannot retroactively changed but will be correct going forward and the care plan was completed on 02/15/2015. B. A root cause analysis was conducted and it was determined that the discuss was not completed on three residents which were isolated occurrences. The root cause analysis conducted showed that the nurses supposed to complete the discuss' did not have a clear understanding of the process and will be re-educated. SSD and DON or designee will be responsible for ensuring a facility wide audit is complete to ensure a discuss is on the chart for the appropriate residents. C. Licensed staff will be re-educated on the process and all new admissions with a psych diagnosis will have a discuss initiated. The DON or designee will be responsible for monitoring. D. The DON or designee will audit all new residents for one month with the goal of 100% compliance, then 5 new residents for one month with the goal of 100% compliance. Results will be reported to QPI Committee for review.	

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F 329	<p>Continued From page 23 contraindicated, In an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R11, R68, R108 and R140) out of 33 Stage 2 sampled residents the facility failed to ensure adequate indication for use and monitoring of psychoactive medications. For R11, R68 and R140, the facility failed to obtain baseline Discus Forms to assess for TD. R108 lacked monitoring for targeted behaviors. Findings include:</p> <p>1. The facility's procedure for Psychoactive medication use required treatment of a documented medically supported psychiatric diagnosis and identified target behavior(s).</p> <p>R108 had physician orders dating back to 6/6/14 for the use of the antipsychotic medication Zyprexa for delusions.</p> <p>A care plan for delusions was not initiated until 2/15/15 and included the goal to reduce the frequency of behavioral symptoms.</p> <p>Review of the medical record lacked evidence that the target behavior of delusions was monitored until 2/10/15.</p> <p>An interview on 3/10/2015 at 9:50 AM with E7 (LPN) and E16 (LPN) revealed that target behaviors would be documented in the EMR. No</p>	F 329			

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F 329	<p>Continued From page 24</p> <p>targeted behavior monitoring was found prior to 2/10/15.</p> <p>An interview on 3/11/2015 at 11:19 AM with E2 (DON) confirmed that the target behavior of delusions was not been put in the medical record for monitoring until 2/10/15. However, the general resident behavior section of the EMR captured six episodes of delusions over the last year.</p> <p>cross refer F281, example #4</p> <p>2. Review of the facility's Discus form, dated 8/01, stated, "be alert for any change from baseline...".</p> <p>On 12/17/14, R140 was evaluated by a psychiatrist and the antipsychotic medication, Risperdal was ordered for delusions. Review of the March 2015 POS revealed that R140 continues to receive Risperdal.</p> <p>Review of the medical record lacked a baseline Discus Form assessment when R140's Risperdal was started in December 2014. There were no Discus assessments.</p> <p>E4 (UM) was interviewed on 3/11/15 at 3:45 PM and confirmed that an Initial Discus was not completed. E4 stated that facility policy was to do a Discus after residents were on an antipsychotic for 6 months and then every 6 months thereafter.</p> <p>The facility failed to obtain a baseline Discus when Risperdal was started in December 2014.</p> <p>3. R11 had the antipsychotic medication, Seroquel ordered on 1/1/15 for delusional disorder. Review of the March 2015 POS revealed that R11 continues to receive Seroquel.</p>	F 329			

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F 329	<p>Continued From page 25</p> <p>Review of the medical record lacked a baseline Discus assessment when R11's Seroquel was started in January 2015. There were no Discus assessments.</p> <p>Findings were confirmed with E4 (UM) during an interview on 3/11/15 at 3:45 PM (see above in example #2).</p> <p>The facility failed to obtain a baseline Discus assessment when Seroquel was started in January 2015.</p> <p>4A. On 12/9/14, R68 was admitted to the facility. R68 had a diagnosis of schizo-affective disorder (condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, such as mania or depression).</p> <p>The interagency discharge orders from the hospital, dated 12/9/14, stated R68's "Home Medications Upon Admission" on 12/4/14 included the antipsychotic medication, Zyprexa. R68's physician continued the order for Zyprexa upon admission to the facility.</p> <p>On 1/28/15, R68 was discharged to a psychiatric hospital and returned to the facility on 2/16/15. R68's physician continued to prescribe Zyprexa on the 2/15 and 3/15 POS and R68 received it per the 2/15 and 3/15 MARs accordingly.</p> <p>Review of R68's medical record lacked a baseline Discus form to assess for TD.</p> <p>During an interview on 3/11/15 at 2:15 PM, E2 and at 2:20 PM, E4 both confirmed the findings.</p>	F 329			

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F 329	Continued From page 26 4B. R68's physician continued the antipsychotic medication, Zyprexa when the resident was admitted to the facility on 12/9/14. Review of the 12/9/14 POS revealed that R68's physician ordered Zyprexa, but the diagnosis for use was blank. The 2/16/15 POS and MAR for R68 stated the diagnosis for Zyprexa was "antipsychotic" which is a drug category, not a diagnosis for indication of use. R68's 3/15 POS and MAR, again, incorrectly listed the diagnosis for Zyprexa was "antipsychotic".	F 329		
F 333 SS=E	During an interview on 3/11/15 at 1:06 PM, E3 (ADON) confirmed the findings. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that residents were free of any significant medication errors on five occasions for one (R68) out of 33 Stage 2 sampled residents. Findings include: The facility's policy and procedure entitled, "10.2 Medication-Related Errors", stated, "Administration Errors... Unauthorized medication	F 333	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS (S/S=E) A. R68s orders were fixed during the survey. B. A root cause analysis was completed and a trend was revealed for short term residents and the accuracy of the recap procedure in relation to the nurses not having a clear understanding of the process, therefore, a re-education will be completed for all licensed nursing staff to ensure accuracy of the monthly recaps which are completed by the end of each month with the goal of 100% compliance. C. The DON or designee will be responsible for conducting and audit of all short term residents for the current months POS for two months. D. If the POS audits are 100% compliance, the DON or designee will audit 5 POS' per month for two months with the goal of 100% compliance. All results will be reported to the QPI Committee for review.	04/28/15

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F 333	Continued From page 27 error: Facility administers a medication dose not authorized for the resident...". Cross refer F281, example 3 Review of R68's physician's progress note, dated 2/18/15, stated that the staff noted bright red blood with bowel movement (BM)... likely local rectal bleed... will need to observe, if persists send to hospital. Plan - monitor for persistent bleeding. R68's physician discontinued Heparin, an anticoagulant (anti-clotting) medication, given by injection every eight hours on 2/18/15. R68's physician's progress notes included: 2/21/15 - No recurrence so far of bright red blood with BM; 2/24/15 - No further rectal bleed...Resolved local rectal bleed. Plan - restart Aspirin. Since the recap done on 2/26/15 of R68's 3/15 POS failed to identify that Heparin was discontinued, the anticoagulant medication incorrectly remained on both the 3/15 POS and MAR. Review of the 3/15 MAR revealed that R68 was incorrectly administered five doses of Heparin, three doses on 3/1/15 and two doses on 3/2/15, without a physician order, resulting in a significant medication error. During an interview on 3/11/15 at 1:06 PM, E3 (ADON) confirmed the findings.	F 333		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	Continued From page 28 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that each resident receives and the facility provides food that is palatable, attractive, and at the proper temperature for one (R22) out of 33 Stage 2 sampled residents. Findings include: After all the trays were passed on the 600 unit lunch cart, the test tray was sampled for palatability and proper temperature. E9 (FSD) recorded temperatures using his thermometer. The "Light and Fit" blueberry yogurt, dated 4/10/15, had a temperature 61.4 degree F and was warm to taste, not palatable. In an interview, on 3/9/15 at 12:25 PM, E9 confirmed the findings and stated he would have expected that yogurt should be around 41 degrees F.	F 364	F0364-NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (S/S=D) A. R22 had no adverse effects from the temperature of the yogurt. B. A root cause analysis was conducted and it was determined that this was an isolated occurrence. All dietary staff will be re-educated on the proper holding temperature during tray line service. C. All yogurts will be put in the freezer 30 minutes prior to the meal and will be held on ice during the tray line to maintain the proper temperatures going forward with the goal of 100% compliance. CDM or designee will be responsible for completing audits of one tray line per day for 30 days with the goal of 100% compliance. D. If weekly audits are 100% compliant, the CDM or designee will audit 5 yogurts per month for one month with the goal of 100% compliance.	04/28/15
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F 371		

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F 371	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and interview It was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include: Inspection of the kitchen with a State Public Health inspector and a surveyor on 3/10/15 from 12:30 PM through 2:40 PM with E9 (FSD) revealed the following: 1. At 12:52 PM, in the food prep area, there were Styrofoam cups being stored in two condiment storage bins, one with the thickener, "Thick It" and the other with pureed bread. Another condiment storage bin was unlabeled. 2. Two knives were stuck behind the container against the wall and not in the nest; 3. At 12:55 PM, in the food prep area, the hand washing sink did not have the required hand washing signage. 4. The handwashing sink hot water temperature read 89.6 degrees F. and failed to meet the minimum temperature of at least 100 degrees F. 5. Additionally, there were four pans on a storage shelf adjacent to the three compartment sink that were stored wet. Findings were reviewed during the informational meeting on 3/11/15 at approximately 4:40 PM.	F 371	F0371-FOOD PROCURE, STORE/PREPARE/SERVE, SANITARY(S/S=F) A. There were no adverse effects to any residents from this citation. B. A root cause analysis was conducted and it was determined that some of the dietary staff needed re-education on the proper food handling and storage procedures. This citation has the ability to affect all residents in the facility and the storage bins have been labeled, the knives removed, the hand washing sink now has signage and is above 100 degrees, and the pans were air dried. C. All dietary staff will be re-educated on the proper storage to prevent wet nesting of pots and pans and the proper labeling of storage bins and not storing Styrofoam cups in the bins. Certified Dietary Manager or designee will conduct audits of all storage bins in the kitchen area for proper labeling and will be responsible for any new storage containers going forward. Audits will be conducted 5 times a week for the proper storage of the pans for 30 days with the goal of 100% compliance. The maintenance director will conduct 5 random audits of the temperature of the hand washing sink per week for 30 days with the goal of 100% compliance. D. If the weekly audits are 100% compliant the Maintenance director will audit 5 temperatures at the hand washing sink per month for one month to ensure continued compliance with a goal of 100%. The CDM will also audit the proper storage procedures for 5 meals for one month to ensure continued compliance if the weekly audits are 100% compliant.	04/26/15	

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F 372 SS=E	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to dispose of garbage and refuse properly. Findings include:</p> <p>On 3/10/15 at 12:30 PM, observations were made by a State Public Health inspector and a surveyor with E9 (FSD) of the compactor and the surrounding area which revealed the following: - There was an accumulation of bagged garbage, soda cans and a potato chip package on the ground under the compactor door; - The compactor wall had a hole near the bottom due to rust on the side next to the compactor door steps.</p> <p>These issues had the potential for harborage and feeding of pests. At the time of the observations on 3/10/15, E9 (FSD) confirmed the findings.</p> <p>The facility faxed emails to the state agency after the survey on 3/16/15 and 3/17/15. These documents were reviewed. However, there was no evidence of facility follow up with the compactor company regarding the compactor wall hole due to rust from December until it was brought to the facility's attention by a State Public Health inspector and a surveyor on 3/10/15.</p>	F 372	<p>F0372-DISPOSE GARBAGE AND REFUSE PROPERLY (S/S=E)</p> <p>A. The accumulative trash was removed at the time of the survey and the trash storage bin has been replaced.</p> <p>B. A root cause analysis was conducted and it was determined that when the compactor was put back in place by the company they did not push it in completely, leaving a gap for trash to collect, which has been fixed. This citation has the potential to affect all residents and has been corrected with no adverse effects on any residents.</p> <p>C. Maintenance director will conduct audits of the compactor area 5 times a week for 30 days to ensure there is no accumulation of trash with the goal of 100% compliance.</p> <p>D. If the weekly audits are 100% compliant the maintenance director will audit the trash bin 5 times for one month with the goal of 100% compliance.</p>	04/28/15
F 428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be</p>	F 428		

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F 428	Continued From page 31 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 review and interview, it was determined that the facility failed to identify any irregularity, failed to report any irregularities to the attending physician and the director of nursing and failed to act upon reports for five (R11, R14, R22, R68 and R140) out of 33 Stage 2 sampled residents. Findings include: The facility's policy and procedure entitled, "9.1 Medication Regimen Review", dated 12/1/07, stated, "The Consultant Pharmacist will conduct MRRs... Facility should ensure that the Consultant Pharmacist has access to:... resident's records... Resident's laboratory tests, Physician/Prescriber progress notes, nurses' notes, and other documents which may assist the Consultant Pharmacist in making a professional judgment as to whether or not irregularities exist in the medication regimen; and any other necessary information... Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendation contained in the MRR...". Cross refer F281, example 1	F 428	F0428-DRUG REGIMEN REVIEW REPORT IRREGULAR, ACT ON (S/S=E) A. R11, R14, R22, R68, and R140 had their orders clarified and corrected before the end of the survey. B. A root cause analysis was completed and a trend was revealed for short term residents and the accuracy of the recap procedure, therefore, a re-education will be completed for all licensed nursing staff to ensure accuracy of the monthly recaps which are completed by the end of each month with the goal of 100% compliance. The consultant pharmacist is auditing 5 resident POS per month and reviewing for any errors or discrepancies. All errors or discrepancies will be reported to the DON immediately to be amended and the consultant pharmacist will document her findings for the facility to review monthly for trends. C. The DON or designee will be responsible for conducting and audit of all short term residents for the current months POS for two months with the goal of 100%. D. If all short term audits are 100% compliant, the DON will then audit 5 residents a month for three months with the goal of 100% compliance and report any errors to the QPI committee.	04/28/15

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F 428	<p>Continued From page 32</p> <p>1. R22's physician ordered an increase to the antidepressant, Remeron on 1/9/15 from 7.5 mg to 15 mg at bedtime. On 1/16/15, R22's physician ordered the antianxiety medication, Vallum 5 mg three times a day.</p> <p>Review of R22's 2/15 POS revealed it lacked both Remeron 15 mg at bedtime and Valium 5 mg three times a day.</p> <p>The MRR done by the consultant Pharmacist on 2/3/15 stated, "NI" (no irregularities) and failed to identify and report that Remeron 15 mg and Valium 5 mg were not on R22's February POS.</p> <p>On 3/9/15 at 7:45 AM, E2 (DON) was interviewed and confirmed the findings. E2 stated the MRR done on 2/3/15 should have identified that neither Remeron nor Valium were on R22's 2/15 POS and reported the irregularities to be acted upon.</p> <p>Cross refer F281, example 2</p> <p>2. On 1/23/15, R14's physician increased the resident's tube feeding of "Jevity 1.5" from 45 ml/hr (milliliters per hour) to 50 ml/hr, up at 12 PM and down at 6 AM. The 2/15 POS was signed 1/23/15. The 3/15 POS which had a recap done on 2/25/15 and signed by R14's physician on 3/3/15 incorrectly continued to state the tube feeding order at 45 ml/hour.</p> <p>On 3/2/15, the facility's consultant pharmacist did an MRR review and indicated "NI". The MRR failed to identify that the 3/15 POS incorrectly stated the "Jevity 1.5" tube feeding rate of 45 ml per hour rather than the actual order of 50 ml per hour.</p> <p>On 3/9/15 at 8 AM, E2 was interviewed and</p>	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2015
NAME OF PROVIDER OR SUPPLIER ARBORS AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720	
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F 428	<p>Continued From page 33</p> <p>confirmed the findings. E2 stated the MRR done on 3/2/15 by the facility's consultant pharmacist should have identified the discrepancy and reported the irregularity to be acted upon.</p> <p>Cross refer F281, example 3 and F333 3A. R68's physician discontinued Heparin, an anticoagulant (anti-clotting) medication, given by injection every eight hours on 2/18/15.</p> <p>Since the recap done on 2/26/15 of R68's 3/15 POS failed to identify that Heparin was discontinued, the anticoagulant medication incorrectly remained on both the 3/15 POS and MAR. R68 was incorrectly given five doses of Heparin, three doses on 3/1/15 and two doses on 3/2/15, without a physician order.</p> <p>On 3/2/15, the facility's consultant pharmacist did an MRR review and indicated "NI". The MRR failed to identify that Heparin was incorrectly administered to R68 without a physician order and failed to report the irregularity to be acted upon. During an interview on 3/11/15 at 1:06 PM, E3 (ADON) confirmed the findings.</p> <p>Cross refer F329, example 4B 3B. Review of the 12/14 through 3/15 POS and MARs revealed that R68 received the antipsychotic medication, Zyprexa, with the diagnosis for use either being blank or incorrectly listing the drug category of "antipsychotic".</p> <p>The facility's MRRs done by the consultant pharmacist completed on 1/5/15 and 3/2/15 both indicated, "NI".</p> <p>The MRRs failed to identify and report the incorrect indication for use/diagnosis of Zyprexa</p>	F 428		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2015
NAME OF PROVIDER OR SUPPLIER ARBORS AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720		
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F 428	<p>Continued From page 34 so it could be acted upon/corrected. During an interview on 3/11/15 at 1:06 PM, E3 confirmed the findings.</p> <p>Cross refer F329, example 4A 3C. Review of the 12/14 through 3/15 POS and MARs revealed that R68 received the antipsychotic medication, Zyprexa.</p> <p>Review of the medical record since admission in 12/14 lacked a baseline Discus form to assess for TD with R68's antipsychotic medication use.</p> <p>The facility's MRRs done by the consultant pharmacist completed on 1/5/15 and 3/2/15 both indicated, "NI".</p> <p>The MRRs failed to identify and report the irregularity that no baseline Discus form was done for R68 so it could be acted upon. During an interview on 3/11/15 at 1:06 PM, E3 confirmed the findings.</p> <p>cross refer F281, example 4 4A. R140 had a physician's order, dated 12/26/14, to add a diagnosis of delusion disorder for the use of Risperdal (antipsychotic medication).</p> <p>Review of R140's January 2015 POS correctly listed delusions as the diagnosis for which Risperdal was given.</p> <p>Review of R140's February and March 2015 POSs, however, incorrectly listed that Risperdal was given for insomnia (an inappropriate indication for use).</p>	F 428			

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F 428	<p>Continued From page 35</p> <p>Pharmacy MRRs completed on 1/5/15, 2/3/15 and 3/2/15 indicated there were no irregularities. The consultant pharmacist, however, failed to identify and report the irregularity that an Inappropriate indication (insomnla) for use of Risperdal was listed on the February and March 2015 POSs.</p> <p>cross refer F329, example 2 4B. Review of the January- March 2015 MARs revealed that R140 received Risperdal since December 2014 (ordered 12/17/14).</p> <p>Review of the medical record lacked a baseline Discus assessment (or any other) when R140's Risperdal was started in December 2014.</p> <p>Pharmacy MRRs completed on 1/5/15, 2/3/15 and 3/2/15 indicated there were no Irregularities. The pharmacist, however, failed to identify and report the Irregularity that a baseline Discus was not done on 1/5/15, 2/3/15 and 3/2/15 MRRs.</p> <p>Findings were reviewed with E2 during the informational meeting on 3/11/15 at approximately 4:40 PM.</p> <p>cross refer F329, example 3 5. Review of the January through March 2015 MARs revealed that R11 received Seroquel (antipsychotic medication) since 1/1/15.</p> <p>Review of the medical record lacked a baseline (or any other) Discus assessment when R11's Seroquel was started in January 2015.</p> <p>Pharmacy MRRs were completed on 1/5/15, 2/3/15 and 3/2/15. The pharmacist, however,</p>	F 428			

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F 428	Continued From page 36 failed to identify and report the irregularity that a baseline Discus was needed on any of these MRRs.	F 428		
F 463 SS=D	Findings were reviewed with E2 during the informational meeting on 3/11/15 at approximately 4:40 PM. 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have a functioning call bell system in two rooms [308A, 204] in one out of two units in the facility. Findings include: 1. On 3/2/15 at 12:42 AM, during Stage 1 survey screening, the call bell in room 308A would not activate the light when pressed. E18 (Facility staff) was made aware and verbalized that maintenance would be made aware. 2. During an environmental tour of the facility on 3/10/15 around 11 AM, the call bells in room 204 beds A and B were not functioning. E15 (Maintenance Director) was present and confirmed the findings.	F 463	F0463-RESIDENT CALL SYSTEM- ROOMS/ TOILET/BATH (S/S=D) A. The call bells in room 308 and 204 are currently functioning properly and have been inspected by maintenance. B. A root cause analysis was conducted and it was determined that these were isolated occurrences. The facility was unable to replicate the problem and all call bells are now functioning properly. A facility wide audit has been completed and all rooms have functioning call bells. C. Maintenance director will conduct 5 random audits per week for 30 days to check the functioning of the call bells in rooms with the goal of 100% compliance. D. If the weekly audits are 100% compliant the maintenance director will audit 5 rooms for one month with the goal of 100% compliance.	04/20/15



**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: March 11, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.7.5	<p>This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey date completed March 11, 2015 - F0166, F0241, F0315, F0325, F0333, F0364, F0463, F0281, F0329, F0428, F0371, F0253, and F0372.</p> <p>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</p> <p>This requirement is not met as evidenced by: Based on observations during the survey, it was determined that the facility failed to comply with sections 5-501.115, 3-304.12(A), 3-302.12, and 5-202.12(A).</p> <p>5-501.115 Maintaining Refuse Areas and Enclosures. A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015 F372</p> <p>5-501.112 Outside Storage Prohibitions. (A) Except as specified in ¶ (B) of this Section, REFUSE receptacles not meeting the requirements specified under ¶ 5-501.13(A) such as receptacles that are not rodent-resistant, unprotected plastic bags and paper bags, or baled units that contain materials with FOOD residue may not be stored outside. (B) Cardboard or other packaging material that does not contain FOOD residues and that is awaiting regularly scheduled</p>	<p>Cross refer to CMS2567 for Annual Survey Completed on March 11, 2015 for plan of correction for F0166, F0241, F0315, F0325, F0333, F0364, F0463, F0281, F0329, F0428, F0371, F0253, and F0372</p> <p>Completion Date: April 28, 2015</p> <p>5-501.115 Maintaining Refuse Areas and Enclosures</p> <p>A. The accumulative trash was removed at the time of the survey and the trash storage bin has been replaced.</p> <p>B. A root cause analysis was conducted and it was determined that when the compactor was put back in place by the company they did not push it in completely, leaving a gap for trash to collect, which has been fixed. This citation has the potential to affect all residents and has been corrected with no adverse effects on any residents.</p> <p>C. Maintenance director will conduct audits of the compactor area 5 times a week for 30 days to ensure there is no accumulation of trash with the goal of 100% compliance.</p> <p>D. Results will be reported to the QPI Committee for review.</p>	<p>04/28/2015</p> <p>04/28/2015</p>

Provider's Signature _____ Title _____ Date _____



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	<p>delivery to a recycling or disposal site may be stored outside without being in a covered receptacle if it is stored so that it does not create rodent harborage problem.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015 F372</p> <p>3-304.12 (A) –In-Use Utensils, Between-Use Storage During pauses in Food Preparation or dispensing , FOOD preparation and dispensing UTENSILS shall be stored:</p> <p>(A) Except as specified under ¶ (B) of this section, in the FOOD with their handles above the top of the FOOD and the container.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015 F371, example 1.</p> <p>3-302.12 – Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015 F371, example 1.</p>	<p>4-901.11- Equipment and Utensils, Air-Drying Required</p> <p>3-302.12 – Food Storage Containers, Identified with Common Name of Food</p> <p>3-304.12 (A) –In-Use Utensils, Between-Use Storage</p> <p>A. There were no adverse effects to any residents from this citation.</p> <p>B. A root cause analysis was conducted and it was determined that some of the dietary staff needed re-education on the proper food handling and storage procedures. This citation has the ability to affect all residents in the facility and the storage bins have been labeled, the knives removed, the hand washing sink now has signage and is above 100 degrees, and the pans were air dried.</p> <p>C. All dietary staff will be re-educated on the proper storage to prevent wet nesting of pots and pans and the proper labeling of storage bins and not storing Styrofoam cups in the bins. CDM or designee will conduct audits of all storage bins in the kitchen area for proper labeling and will be responsible for any new storage containers going forward. Audits will be conducted 5 times a week for the proper storage of the pans for 30 days with the goal of 100% compliance. The maintenance director will conduct 5 random audits of the temperature of the hand washing sink per week for 30 days with the goal of 100% compliance.</p> <p>D. The results of these audits will be presented to the QPI Committee for review.</p>	<p>04/29/15</p>
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	<p>5-202.12 Hand washing Sink, Installation (A) A HAND WASHING SINK shall be equipped to provide water at a temperature of at least 38°C (100°F) through a mixing valve or a combination faucet.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015, F371 example 4.</p> <p>4-901.11- Equipment and Utensils, Air-Drying Required After cleaning and SANITIZING, Equipment and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingrediants for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed March 11, 2015, F371 example 5.</p>		

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