

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

PRINTED: 07/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEW CASTLE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 BUENA VISTA DRIVE</b> <b>NEW CASTLE, DE 19720</b>		
(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  An unannounced complaint visit was conducted at this facility from June 23, 2015 through July 1, 2015. The deficiencies contained in this report are based on interview, review of the resident's clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 107. The survey sample included five (5) records; three (3) active and two (2) closed.  Abbreviations used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MAR - Medication Administration Record.	F 000	F157 A.R1 was discharged from the facility on 5/27/15 to her home. B. All residents with physician notification requirements based upon blood glucose parameters are at risk.  C. Nursing staff will be in-serviced that all routine vitals monitoring, including blood glucose monitoring, where the result falls outside the specified parameters, the Nursing Supervisor, will be notified. The Nursing Supervisor is responsible for ensuring that the prescribed actions, including physician notification, are completed and documented in the resident record. D. The Director of Nursing or her designee will audit 10 records per week for 8 weeks to ensure compliance. Any variances will be reported to the Administrator and addressed through the Quality Assurance process.	8/17/15	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157			

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

*[Handwritten Signature]*

TITLE

*NHA*

(X6) DATE

*7-24-15*

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 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157			
	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, facility documentation and interview, it was determined that for one resident (R1) out of 5 sampled, the facility failed to notify the physician on 4/16/15 when R1's blood glucose (measures the amount of blood sugar in the blood/normal=70-100 mg/dL [milligrams per deciliter]) exceeded physician ordered parameters and had the potential to require physician intervention. Findings include:</p> <p>The facility policy, dated October 1999 and last revised in July 2014, entitled "Notification of Resident Change in Condition" stated, "... Notify the physician ... at the earliest possible time, during waking hours, if there is a non-critical change in condition (unless requested to do otherwise)... Document in the Nurses Notes the times notification was made and the names of the person(s) to whom you spoke..."</p> <p>R1's care plan, dated 3/20/15 and entitled, "Diabetes [disease with high blood sugar levels] Plan of Care" included the intervention, "... Report</p>				

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F 157	<p>Continued From page 2</p> <p>blood glucose results that exceed low and high parameters' to physician (doctor)...".</p> <p>R1's physician's order for Novolin 70/30 (Insulin, medicine to treat diabetes), dated 3/20/15, stated the resident was to have an "...Accucheck (meter used to measure blood sugar level in the blood) twice a day. Notify doctor if blood sugar is greater than 250".</p> <p>Review of R1's April 2015 MAR stated that the resident's accucheck done at 7:30 AM on 4/16/15 was 314.</p> <p>Review of R1's Nurse's Notes on 4/16/15 lacked evidence that the doctor was notified.</p> <p>During an interview on 7/1/15 at 11:08 AM, E2 (DON) confirmed the findings and stated R1's blood sugar result was not put in the doctor's (notification) book nor was it included in the 24 hour status report (to document changes).</p> <p>During an interview on 7/1/15 at 11:30 AM, E6 (Physician) reviewed R1's April 2015 MAR and stated he could not remember if he was "notified back that far (April 2015)". E6 confirmed that he ordered to be called if a blood sugar was greater than 250 and he expected to be informed. E6 stated that staff usually put the information in the doctor's book. E6 was informed that R1's blood sugar result was not in the doctor's book. When asked if he would have changed or ordered anything different if he had been notified of R1's blood sugar of 314, E6 stated, "No, not in this case."</p> <p>The facility failed to notify R1's physician when there was a change in blood glucose exceeding</p>	F 157			

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F 157	Continued From page 3 ordered parameters with potential for requiring physician intervention. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit meeting on 7/1/15.	F 157	F282	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interview, it was determined that the facility failed to provide service in accordance with the resident's "Skin Integrity Assessment: Prevention and Treatment Care Plan" for 1 resident (R2) out of 5 sampled. Findings include:  R2's care plan, dated 9/6/14 (last revised on 5/17/15) and entitled, "Skin Integrity Assessment: Prevention and Treatment Care Plan" had interventions which included, "... Use rolled blanket to separate feet; offload (removal of pressure from an area) heels while in bed...".  On 6/23/15 at 10:25 AM, a black heel cushion (device used to offload heels over the bed to prevent contact with surface of the mattress) was observed on top of R2's bed linens at the foot of her bed while she was in bed. Findings were discussed with E3 (CNA), who stated that the assigned CNA was with another resident and offered to "fix it". When E3 pulled the linens back, R2 was observed with a folded pillow under her	F 282	A. R2 remains a resident of the facility. B. The Unit Manager is monitoring R2's skin interventions daily. Other residents with prescribed heel off-loading are at risk. C. All Nursing and Certified Nursing Assistants will receive in-servicing on skin interventions and ensuring treatment modalities are in place. D. The Unit Manager will monitor all identified residents with skin treatment interventions on a daily basis to ensure compliance. Any variances will be reported to the Director of Nursing and additional staff education and/or discipline will be conducted. Actions will be reported through the QA process.	8/17/15

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F 282	<p>Continued From page 4</p> <p>knees and with a rolled blanket to separate her legs. R2's heels were observed in direct contact with the mattress. E3 stated that R2 was supposed to have the heel protector in place at all times while in bed, except during meal times because it caused the over bed table to be "too high" for meals. E3 stated that after meals, the heel protector was supposed to be put back in place. The surveyor informed E3 of the time (10:25 AM) and E3 confirmed that breakfast had been over for some time. E3 immediately repositioned R2 so that her heels were properly off loaded.</p> <p>On 6/23/15 at 12:50 PM, R2's heel cushion was observed on top of the resident's chest of drawers while the resident was in bed. E4 (CNA) confirmed that R2 's heels were in direct contact with the mattress and not properly off loaded.</p> <p>On 6/25/15 at 9 AM, R2 was observed with her knees bent under the covers. The heel protector was not visible, so E5 (LPN) was requested to pull back R2's covers. R2's heels were observed in direct contact with the mattress. Although a pillow was observed under R2's knees with the heel cushion on, neither was correctly positioned to ensure that the resident's heels were properly off loaded. E5 confirmed the finding and explained the heel cushion had straps attached that could be used to "anchor it" in place and prevent the resident from moving it. E5 immediately off loaded R2's heels by using the attached straps to secure it in place.</p> <p>On 6/30/15 at 10:05 AM, R2's heel cushion was observed on top of a geri chair (wheelchair type - chair that reclines) across the room. E6 (CNA) was asked why R2's heel cushion was not in use.</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>E6 pressed down on the linens with her hands and stated R2's heels were being off loaded by a pillow. At the surveyor's request, R2's feet were uncovered and R2 was wearing socks. R2 had her left leg crossed over her right leg, her right heel was in direct contact with the mattress and her left heel was flat on the pillow and not properly off loaded. Additionally, R2 was observed without a rolled blanket between her legs (used to prevent pressure or skin irritation from bone on bone contact). Findings were confirmed with E6.</p> <p>On 6/30/15 at 10:45 AM, findings were discussed with E1 (NHA). E1 confirmed that R2's heels were to be off loaded at all times while in bed and that R2's care plan did not list meal times as an exception. E1 was informed that despite staff stating R2 could not use the heel cushion during mealtimes because it interfered with placement of the over bed table, there was an observation during the survey of R2 doing exactly that without any problem.</p> <p>The facility failed to provide service in accordance with the resident's care plan. The facility failed to ensure that R2's heels were always off loaded while she was in bed and a rolled blanket placed between her legs.</p>	F 282			



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

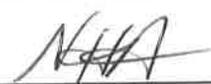
**STATE SURVEY REPORT**

NAME OF FACILITY: New Castle Health and Rehabilitation Center

DATE SURVEY COMPLETED: July 1, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint visit was conducted at this facility from June 23, 2015 through July 1, 2015. The deficiencies contained in this report are based on interview, review of the resident's clinical record and other facility documentation as indicated. The facility census on the first day of the survey was 107. The survey sample included five (5) records, three (3) active and two (2) closed.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 1, 2015 F157 and F282</b></p>	<p>Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws.</p> <p>Cross reference CMS 2567L – F 157 and F282</p> <p>1. Facility staffing report submitted to the State for review was completed by an employee who is no longer employed by the facility.. The accuracy of the information provided is under facility's review.</p> <p>2. The facility Scheduler is responsible for maintaining adequate staffing to ensure Compliance with State regulations. Counselling was provided to emphasize the necessity to meet regulations and alternative resources for meeting staffing mandates.</p> <p>3. The Director of Nursing or Designee will ensure required Staffing levels are met daily.</p>	<p>8/17/15</p>
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Provider's Signature  Title  Date 7/24/15



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	<p><b>16 Del. C., 1162 Nursing Staffing:</b></p> <p><b>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</b></p> <p><b>Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:</b></p> <table border="0" data-bbox="251 1087 846 1260"> <tr> <td></td> <td style="text-align: center;"><b>RN/LPN</b></td> <td style="text-align: center;"><b>CNA*</b></td> </tr> <tr> <td><b>Day</b></td> <td style="text-align: center;">1 nurse per 15 res.</td> <td style="text-align: center;">1 aide per 8 res.</td> </tr> <tr> <td><b>Evening</b></td> <td style="text-align: center;">1:23</td> <td style="text-align: center;">1:10</td> </tr> <tr> <td><b>Night</b></td> <td style="text-align: center;">1:40</td> <td style="text-align: center;">1:20</td> </tr> </table> <p><b>* or RN, LPN, or NAIT serving as a CNA.</b></p> <p><b>(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.</b></p> <p><b>The law was not met as evidenced by:</b></p> <p>Three weeks of facility staffing, covering the period of 31 May 2015 through 20 June 2015 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Arbors staff, and signed by the Administrator. The three (3) citations hereon result from that work.</p>		<b>RN/LPN</b>	<b>CNA*</b>	<b>Day</b>	1 nurse per 15 res.	1 aide per 8 res.	<b>Evening</b>	1:23	1:10	<b>Night</b>	1:40	1:20	<p>4. Variances will be reported to the Administrator and addressed through the QA Process. The QAPI Committee meets monthly and as needed to review the corrective action and the effectiveness of the plan of correction. The QAPI Committee will direct improvement to the plan when necessary to achieve and maintain compliance with intent to prevent reoccurrence.</p>	
	<b>RN/LPN</b>	<b>CNA*</b>													
<b>Day</b>	1 nurse per 15 res.	1 aide per 8 res.													
<b>Evening</b>	1:23	1:10													
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	<p>New Castle Health and Rehabilitation Center failed to meet the 3.28 daily Care Hours per Resident requirement on the three (3) days shown below. The Care Hours per Resident attained by New Castle Health and Rehabilitation Center each day are parenthesized.</p> <ol style="list-style-type: none"> <li>1. Monday 8 June 2015 (3.26).</li> <li>2. Friday 12 June 2015 (2.99).</li> <li>3. Saturday 20 June 2015 (3.10).</li> </ol>		

Provider's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_