

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

PRINTED: 07/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940	
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from June 15, 2015 through June 23, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 93. The survey sample totaled twenty nine (29).</p> <p>Abbreviations/Definitions used in this 2567 are as follows: NHA- Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM- Unit Manager; MD - Medical Doctor; RNAC- Registered Nurse Assessment Coordinator; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); CNA - Certified Nurse's Aide; FSD- Food Service Director; RD- Registered Dietitian; ADLs - Activities of Daily Living, such as bathing and dressing; mg- milligrams; PT- physical therapy; Hoyer lift-device to aid in transfer of residents between surfaces; FSBS - finger stick blood sugar; MAR - Medication Administration Record;</p> <p>Urinary incontinence- inability to prevent accidental leakage of urine from bladder; Urinary continence - ability to prevent accidental leakage of urine from bladder;</p>	F 000	<p>Delmar Nursing and Rehabilitation Center's plan of correction for the deficiencies noted during our annual survey ending June 23, 2015 is not an admission to the deficiencies, but our desire to show compliance with all Federal and State regulations.</p>	

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

TITLE

(X6) DATE

[Handwritten Signature]
RN

D.O.N.

8/8/15

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 159	<p>Continued From page 2</p> <p>funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that for 5 (RP1, RP2, RP3, RP4 and RP5) out of 29 samples residents the facility failed to ensure residents had access to their personal funds on weekends. Findings include:</p> <p>The facility policy for Resident Funds stated that withdrawals can be made during regular business hours Monday through Friday by the resident, guardian and Power of Attorney (POA). Funds are available during business hours up to 5:00 PM during the week and up to 8:00 PM on weekends. On weekends, funds are available in a secure location with front desk staff.</p>	F 159	<p>Facility Business Office Coordinator or designee will complete random weekly audits to ensure that funds are accessible to residents on the evenings and weekends. The audit will include resident interviews to ensure that the residents have accessibility to funds on evenings and weekends as well as staff interviews to ensure that the staff members are aware of the RFMS policy and procedure as it relates to off hours access to funds. Audit results will be reported to the facility Quality Assurance Committee for a minimum of monthly x 3.</p> <p>F167</p> <p>Corrective measures for residents affected: The facility survey binder has been updated and contains the survey results for the prior three years. The binder has been placed in the main lobby to allow easy accessibility for facility residents, staff and family members to review the information. Signs have been placed in the lobby and throughout the facility to inform residents, staff and guests of the binder's location.</p> <p>Identification of others with the potential to be affected: Facility Residents have the potential to be affected.</p>	08/22/2015

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F 159	Continued From page 3 During an interview on 6/18/15 at 11:48 AM E5 (Business Manager) revealed that in the evenings and on weekends, cash is placed in a secured location with front desk staff. E5 also stated that nursing staff were aware of the availability of cash for residents. Interviews with 5 (RP1, RP2, RP3, RP4, RP5) out of 29 sampled residents reported that they did not have access to funds during non-business hours and on weekends. Interviews on 6/19/15 between 11:40 AM and 11:45 AM with nursing staff revealed that 2 LPN's (E8 & E12) out of 3 nursing staff did not know how residents were able to access funds if the business manager was not available. Findings were reviewed and confirmed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM. 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by:	F 159	Measures to prevent Recurrence: Facility Activity Director presented information to the resident council on the location of the survey results in the facility. Residents were advised that the results were accessible to them at any time for their review. (Exhibit 5, resident Council sign in sheet) Facility Nurse Educator provided an in-service to facility staff on the Survey Results policy (See Exhibit 3, Exhibit 4). This education included the location and contents of the survey binder. Staff members were educated on the fact that the survey results were available for residents, staff members and visitors to review at any time. Monitoring of Corrective Action: Facility LNHA or designee will complete random audits to ensure that the binder containing the survey results remains in an easily accessible location. Audit results will be forwarded to the facility Quality Assurance Committee for a minimum of monthly x 3. (See Exhibit 6) F241	08/22/2015
F 167 SS=C		F 167	Corrective measures for residents affected: There was no negative outcome to residents E20, E21, E22 or E14. Identification of others with the potential to be affected: Facility residents have the potential to be affected.	

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F 167	Continued From page 4 Based on observation and interviews, it was determined that the facility failed to ensure that survey results were accessible to residents without residents having to request to see them. Additionally, the facility failed to post a notice of their availability. Findings include: R77 (Resident Council President) was interviewed on 6/18/15 at approximately 9:30 AM. When asked if survey results were available to read without having to ask, R77 stated he did not know there was a survey book with survey results. On 6/18/15 at 10:55 AM, the survey book was observed high up the wall in a clear lucite holder to the left of the receptionist desk. The clear holder had a label that stated "SURVEY" in approximately 1/2 inch black letters. The label/survey book faced the receptionist and was not easily visible to others. Additionally, there were no signs in the lobby or elsewhere in the building to let residents know where the survey results were. Findings were confirmed with E1 (NHA) during an interview on 6/18/15 at 11:00 AM. E1 stated she did not know how the survey book got up there, that she had it on the side table in the lobby as you enter the facility. The facility failed to have survey results readily accessible to residents for examination and failed to have a notice of their availability posted.	F 167	Measures to prevent Recurrence: Facility nurse educator provided education to facility staff on the importance of maintaining resident dignity as it pertains to entering a resident's room. This education included the need to stop at the resident's door, knock and ask for permission to enter the room and waiting for permission prior to entering the room. (See Exhibit 3 and Exhibit 8) Monitoring of Corrective Action: Director of Nursing or designee will complete random audits to ensure that facility employees are stopping at the residents door, knocking and asking for permission to enter the room and waiting of the resident to give permission to enter prior to entering the room. Audit results will be forwarded to the facility Quality Assurance Committee for a minimum of monthly x 3. (See Exhibit 9) F246	08/22/2015	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	The light cord in room 112-2 has been repaired and is now long enough for resident R91 access from the bed.		

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F 241	<p>Continued From page 5</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on multiple observations, it was determined that for 4 (R104, R7, R31 and R71) out of 29 residents the facility failed to promote care in a manner that promotes or enhances dignity. Findings include:</p> <p>During breakfast observations in the Henlopen halls on 6/15/15 from 7:50 AM to 8:10 AM, the following were observed while trays were being passed:</p> <ol style="list-style-type: none"> 1. E20 (CNA) entered resident room 305-1 (R104). She knocked and entered without asking for permission to enter. 2. E21 (CNA) entered resident room 301-2 (R7). She knocked and entered without asking for permission to enter. 3. E22 (Restorative Aide) entered room 306 (R31). She knocked and entered without asking for permission to enter. 4. E14 (CNA) entered resident room 305-2 (R71) without knocking or asking for permission to enter. <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM.</p>	F 241	<p>The light cord in room 215-1 has been repaired and is now long enough for resident R83 to access from her bed.</p> <p>Identification of others with the potential to be affected: Facility residents have the potential to be affected.</p> <p>Facility Director of housekeeping completed an audit to ensure that all residents had a call bell clip in place to secure the call bell in a location that can be easily accessed by the resident.(See Exhibit 10)</p> <p>Facility Director of Maintenance completed a house wide audit to ensure that the over the bed light cords were long enough to be accessed by the resident from bed.(See Exhibit 11)</p> <p>Measures to prevent Recurrence:</p> <p>Facility nurse educator provided education to facility staff on the importance of ensuring that call bells are in reach and accessible to the resident at all times. This included education on using the call bell clip to secure the call bell in a place that can be accessed by the resident.</p> <p>Facility Nurse Educator completed education with facility staff members on the need to report over the bed call bell cords to the maintenance department when they are too short and they can not be accessed by the resident.</p>		

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F 246 F 246 SS=D	Continued From page 6 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide reasonable accommodation of needs for 3 (R28, R83 and R91) out of 29 sampled residents. R28's call bell was not within reach on three occasions. R83 and R91 had short pull cords on their wall-mounted overbed lights making them inaccessible while in bed. Findings include: 1. On 6/15/15 at 12:37 PM, R28's call bell was hanging inside the left rail of the bed and it was out of reach. On 6/18/15 at 11:30 AM, R28's call bell was hanging inside the left side rail of the bed hanging approximately 4-5 inches from the floor; it was out of reach. On 6/19/15 at 8:03 AM, while R28 was asleep in bed, the call bell was hanging inside the left side rail of the bed hanging approximately 4-5 inches from the floor; it was out of reach. Review of R28's care plan revealed interventions	F 246 F 246	Facility Administrator completed education with the maintenance department on the importance of a preventative maintenance program. This included the need for daily walking rounds to observe the physical plant and identifying areas that need correction to include the over the bed light cords. (See Exhibit 3, See Exhibit 12) Monitoring of Corrective Action: Director of Nursing or designee will complete random audits to ensure that facility residents have their call bell in reach at all times when they are in their rooms. Audit results will be forwarded to the Quality Assurance Committee monthly x 3. (See Exhibit 10) Administrator or designee will complete random audits of the physical plant to ensure that over the bed light cords are long enough to be accessible by the resident from the bed. Audit results will be forwarded to the facility Quality Assurance Committee monthly x 3. (See Exhibit 11) F253 Corrective measures for residents affected: There was no negative outcome to residents affected. 1. The scratches/scuffs on the door to the ice room have been repaired. 2. Metal door frames for the shower rooms, kitchen, ice room, DON's office and public bathrooms have been repaired.	08/22/2015	

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F 246	Continued From page 7 initiated on 2/20/15 and last revised on 5/12/15 to keep the call bell within reach and to encourage R28 to use the call bell when she recognizes the need to use the bathroom. On three occasions the call bell was hanging on the left side rail out of reach for this resident. 2. On 6/15/15 at 9:28 AM in room 112-2 the wall-mounted overbed light cord was hanging 5-6 inches below the light fixture, too short for R91 to access while in bed. 3. On 6/15/15 at 2:24 PM in room 215-1 the wall-mounted overbed light cord was hanging 5-6 inches below the light fixture, too short for R83 to access while in bed. Findings were discussed with E10 (Director of Maintenance) on 6/18/15 during the environmental tour between 1:50 PM - 3:25 PM. The facility failed to ensure that R28's call bell was within reach and R83 and R91 could turn on their overbed lights while in bed. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM.	F 246	3. The electric wires running to the ecolab bug light on station one and memory care have been secured. 4. The areas identified in the shower/tub room on station 2 have been repaired. The shower room floor has been cleaned. The personal laundry container has been removed from the room. The missing floor tiles around the drain have been repaired. The sink clips have been replaced. The room has been repainted. The resident care items (wheelchairs/hoyer lifts) have been removed from the room. 5. The areas identified in the shower room on the memory unit have been repaired. The hamper and wheelchairs have been removed from the room. The damaged raised toilet seat has been thrown away along with the open bottles of shampoo and the hair tie. The three wall panels that were bowed have been repaired, along with the chipped paint and missing tiles. The screw holes observed have been filled. The gap along the shower has been repaired. The area of discoloration located along the gap has been corrected. The duct tape around the air conditioner has been removed and the unit has been framed in.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 253	6. The door handle on the electrical room has been repaired. The door remains locked and can only be opened by staff members with a key. 7. The unopen boxes on the memory care unit have been removed and placed in the facility storage room.		

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F 253	<p>Continued From page 8</p> <p>determined that the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly and comfortable interior. Findings include:</p> <p>During the initial tour on 6/15/15 between 07:40 AM - 8:30 AM, the following findings were observed:</p> <ol style="list-style-type: none"> 1. Scratched/scuffed doors: entry to ice machine and kitchen. 2. Metal door frames with rust, chipped paint and rough surfaces present in shower rooms on all three units, kitchen, entry to ice machine room, DON office, and public bathrooms. 3. Unsecured electric wires (over 3 feet) running down the wall behind the hallway handrail from Ecolab wall-mounted flying pest elimination devices (bug lights) to the electric outlet on Station 1 (near room 109) and the Memory Care unit (near room 212). 4. Shower/tub area on Station 2 by room 206: hooyer lift was stored in the middle of the entry hallway making it difficult to walk into the area; entry hall with dirt along the floor edges and scuffed lower walls; shower area floor dirty and personal laundry container (without lid) and laundry in a plastic bag stored in this area; missing floor tiles around floor drain in both shower and tub areas; tub area had a dirty floor and three wheelchairs were stored along with a hooyer lift (wheelchair stored in front and partially covering the toilet blocking its use); rusty clips attaching sink water pipe to wall; blistered, chipped paint behind toilet; dried, stained evidence of a drip and puddle below wall-mounted heater in tub area. 	F 253	<ol style="list-style-type: none"> 8. The boxes located on memory unit have been removed, unpacked and placed in the medical supply closet. 9. Boxes located in the storage closet on the memory unit have been removed from the floor and unpacked and placed on the shelves. The empty boxes were taken to the dumpster. 10. The basket of condiments has been removed from the dining room. The plastic cups were discarded. 11. <ol style="list-style-type: none"> a. The scratch marks located in R18's room have been repaired and painted. b. The scratched and spackled marks in R31's room have been repaired and repainted. c. The unpainted areas in R106's room have been repaired and painted. The gouges and hole on the bathroom door has been repaired. d. The unpainted areas in R45's room have been painted and repaired. e. The ceiling tiles in R93's bathroom have been replaced. The door frame has been repaired and the unpainted spackled areas noted have been painted. f. The chipped paint in R75's room has been repaired. The bathroom floor has been cleaned. g. The scuff marks located on the walls, headboard and closet in R6's room have been repaired, h. The scuffed walls and doors located in R28's room/bathroom have been repaired. 	

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F 253	<p>Continued From page 9</p> <p>5. Shower room on Memory Care unit: entry had a dual trash/linen hamper in hallway making it difficult to enter the area; toilet area had two large, round linen hampers blocking the entrance to the room; pre-shower area had 5 wheelchairs and a dual trash/linen hamper restricting entry into the area; on top of the dual trash/linen cart was a raised toilet seat with a wheelchair cushion with a torn edge and exposed inner foam; two open bottles of shampoo and a used hair tie with pieces of hair attached observed on top of the wall-mounted heater/air conditioner unit; left side of the room had three wall panels (4 x 8 feet) that were bowed and separated from underlying drywall; toilet area had chipped paint in corners with exposed drywall; tiled pre-shower area walls had two areas with missing tiles (one with a hole in underlying wall) and over a dozen unused screw holes: shower stall had 1 inch gap along the entire right side of a panel (approximately 5 x 4 1/2 feet) covering the bottom part of the tiled wall (black mold seen along this gap (worse at the bottom) and on the top of the panel below the soap dispenser); wall-mounted heater/air conditioner unit had white duct tape around outside of unit attached to the wall.</p> <p>6. Electric closet on Memory Care unit near room 214 had a hole around the door handle and was able to be pulled open exposing the electrical fuse panel and wires hanging from the telephone panel.</p> <p>7. Memory Care unit hallway next to the nursing station: unopened boxes sitting on the floor (2 boxes of cups, 2 boxes of plastic spoons, 1 box of cup lids, and 1 box of paper towels).</p>	F 253	<p>i. The door frame has been repaired in R33's bathroom. The non-painted areas have been painted and the floor tile has been replaced.</p> <p>j. The scuff marks identified in R17's room have been repaired.</p> <p>k. The duct tape around the ac unit in R19's room has been removed and the unit has been framed in. The bathroom door frame has been repaired.</p> <p>l. The open area around the pipe has been repaired.</p> <p>m. The scratched paint in R35's room has been repaired.</p> <p>12</p> <p>a. The blistered paint behind the toilet in R77's bathroom has been repaired.</p> <p>b. The scratches and scuffed paint in R20's room has been repaired.</p> <p>c. The unpainted spackled areas located in R54's room has been painted. The paint damage behind the bed has been painted.</p> <p>d. The toilet bowl in room R91 has been cleaned. The scratched walls in the room have also been repaired.</p> <p>e. The damaged drywall in R105's room has been repaired.</p> <p>f. The damaged drywall in R86's room has been repaired. The spackled areas have been painted.</p> <p>g. The ceiling tiles in R111's room have been replaced. The damage to the drywall has been repaired and the area</p>	
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F 253	<p>Continued From page 10</p> <p>8. Memory Care unit hallway outside storage closet: 3 boxes of disposable briefs (1 was open); 1 unopened box of cups, unopened box with an umbrella stand, and 3 uncovered oxygen concentrators were observed on the floor.</p> <p>9. Electric/Storage closet to the left of Memory Care unit nursing station: one large box (approximately 2 x 3.5 feet) filled with at least 8 used flattened boxes was on the floor in front of the two electrical panels (nearly all of the box within the red line marked on the floor). Signage on the electric panels stated "All staff. Nothing can go on the floor or in front of the power boxes. Storage must be on shelves and must not be stacked to the height of the panel per the Fire Marshall". Six boxes of disposable briefs were found on the floor (1 box was opened). Shelves in the storage area only had a few bags of disposable briefs stored on them with most of the shelves being empty.</p> <p>10. Dining/Activity room on Memory Care unit: basket of condiments (sugar, mustard, et cetera) sitting on sink by hot water faucet below soap dispenser; open cups sitting upside down directly on sink by hot water faucet.</p> <p>On 6/15/15 the following findings were observed:</p> <p>11 A. 10:38 AM: R18's room had scratched wall paint.</p> <p>B. 10:59 AM: R31's room had unpainted spackled areas over the bed and side walls and scratched wall paint in the bathroom.</p> <p>C. 11:22 AM: R106's room had an unpainted</p>	F 253	<p>has been repainted. The door frame has been repaired to allow easy opening and closing of the door.</p> <p>13 The areas identified in station three shower room have been corrected. The blistered scratched paint has been repaired/painted. The duct tape around the AC unit has been removed and the unit has been framed in. The broken/missing tiles have been repaired. The stains on the shower room floor have been removed.</p> <p>14a. The items in the hallway on the memory care unit have been removed.</p> <p>b. The unopened boxes in the storage room closet have been removed.</p> <p>Identification of others with the potential to be affected: Facility residents have the potential to be affected.</p> <p>Facility Director of housekeeping completed an audit to ensure that the physical plant is clean. The inspection included the resident rooms and bathrooms. (See Exhibit 14)</p> <p>Facility Director of Maintenance completed a house wide audit to ensure that the physical plant is in good physical condition. This included an audit of door frames to ensure that they are smooth and well painted, walls to ensure that they are free from holes and painted, floors to ensure that there are no broken/missing tiles, AC units to ensure that they are not secured by duct tape and are framed in appropriately. (See Exhibit 14)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
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NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940
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F 253	<p>Continued From page 11</p> <p>spackled area on the wall over the bed; blistered and cracking wall paint behind toilet; horizontal gouges and a hole on the inside of the bathroom wood door from wheelchair contact.</p> <p>D. 11:35 AM: R45's room had unpainted spackled areas on the wall over the bed and blistered and cracking wall paint behind toilet.</p> <p>E. 11:53 AM: R93's bathroom had stained ceiling tiles; rust, chipped paint and rough surfaces on the bathroom door frame and an unpainted spackled area on the outer wood bathroom door.</p> <p>F. 11:54 AM: R75's room had chipped wall paint by the window and sink and the bathroom floor was dirty.</p> <p>G. 12:07 PM: R6's room had scratches and scuff marks on the wall behind the bed, the headboard and the bottom of the closet door.</p> <p>H. 12:14 PM: R28's bathroom walls and door were scratched at the bottom from wheelchair contact.</p> <p>I. 2:18 PM: R33's room had an unpainted area behind the bed where the call light box used to be attached; rust, chipped paint and rough surfaces on the bathroom door frame; floor tile missing at the entryway into the bathroom (approximately 1 x 30 inches).</p> <p>J. 2:28 PM: R17's room had scratched and scuffed walls from wheelchair contact.</p> <p>K. 2:35 PM: R19's wall-mounted heater/air conditioner had white duct tape around the</p>	F 253	<p>Maintenance Director completed an audit to ensure that the hallways and storage areas are free from clutter to include boxes on the floors or under the electrical panels. (See Exhibit 14)</p> <p>Maintenance Director completed an audit to ensure that all wiring located in the building is secured. (See Exhibit 14)</p> <p>Maintenance Director will complete an audit of facility doors to ensure that they lock appropriately. (See Exhibit 14)</p> <p>Measures to prevent Recurrence:</p> <p>Facility nurse educator provided education to facility staff on the importance of reporting maintenance issues to the maintenance department when discovered. This includes chipped or scratched paint, broken or missing floor tiles and hanging wires. (Exhibit 3)</p> <p>Facility Nurse Educator completed education with facility staff members on the importance of keeping the hallways and storage rooms free of clutter. This includes the need to put all medical supply orders away once received. Education also included the importance of not placing items under the electric boxes. (Exhibit 3)</p> <p>The Maintenance Director that was in place during the survey is no longer employed at the facility. The facility currently has in place a preventative maintenance program called the Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified</p>	
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F 253	<p>Continued From page 12</p> <p>outside of the unit where it was attached to the wall and rust, chipped paint and rough surfaces on the bathroom door frame.</p> <p>L. 2:55 PM: R71's room sink had an open area around the cold water pipe from a displaced flange.</p> <p>M. 5:54 PM: R35's walls and doors had scratched paint.</p> <p>On 6/16/15 the following findings were observed:</p> <p>12A. 9:06 AM: R77's bathroom wall had blistered paint behind the toilet.</p> <p>B. 9:10 AM: R20's walls had scratched and scuffed paint.</p> <p>C. 9:22 AM: R54's room had paint damage behind the bed and an unpainted, white spackled stripe on the wall.</p> <p>D. 9:28 AM: R91's room had scratched walls, and a brown stain smeared inside the toilet bowl.</p> <p>E. 10:01 AM: R105's room had damaged drywall.</p> <p>F. 10:03 AM: R86's room had damaged drywall behind the bed; an unpainted, white spackled stripe on the wall, and a brown stain inside the toilet bowl.</p> <p>G. 11:54 AM: R111's bathroom had stained ceiling tiles, four holes in the drywall over the sink, chipped paint on the bathroom door, and the metal bathroom door rubbed against the door frame making it difficult to open and close.</p>	F 253	<p>during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to document findings during the rounds as well as the procedure for reporting identified concerns. (Exhibit 36, 37)</p> <p>Monitoring of Corrective Action:</p> <p>Director of Nursing or designee will complete random audits to ensure that medical supplies are put away timely and that hallways and storage areas are clear. Audit will also focus on shower rooms to ensure that they are free from clutter and accessible to residents. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% success is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the Quality Assurance Committee. (See Exhibit 15)</p> <p>Administrator or designee will complete random audits of the physical plant to ensure that the physical plant is in good repair. Audit will focus on paint, door frames, ac units, tiles, door handles and locks and overall condition.</p>	

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F 253	<p>Continued From page 13</p> <p>13. On 6/18/15 at 11:30 AM the Station 3 shower area had blistered, scratched paint in the toilet area, the wall-mounted heater/air conditioner unit had white duct tape around the outside of the unit where it was attached to the wall, the shower area had several broken wall tiles near the floor on the wall below the shower head and missing grout between tiles on both walls and floor, and there was a brown stain on the shower floor.</p> <p>14A. On 6/18/15 at 2:10 PM the Memory Care unit hallway outside the storage closet had the following items on the floor: 1 opened box of cups, an unopened box with an umbrella stand and 5 uncovered oxygen concentrators.</p> <p>B. On the floor inside the storage closet were: 2 unopened boxes of disposable briefs and 1 oxygen concentrator, within the red line in front of the electric panels.</p> <p>Interview with E10 (Maintenance Director) during the environmental tour on 6/18/15 between 1:50 PM - 3:25 PM revealed that the facility used a computer program (Direct Supply TELS.) to track weekly and monthly inspections and maintenance. E10 stated that he moves the boxes from in front of the electric panels "every day". E10 stated that he wants to re-do the entire shower area.</p> <p>On 6/19/15 at 8:50 AM, E10 provided a print out of logbook documentation for the weekly inspection done 6/12/15 by E11 (Maintenance Technician), that included room 202. The document recorded that the bathroom in room 202 had "fixtures clean and functioning correctly. No chips or rust". Noted in the comment section for this room, was "patch bathroom hole".</p>	F 253	<p>The sample size will be 5 patient care areas per audit and the sample areas will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Administrator or designee will complete random audits of the physical plant to ensure that the physical plant is in good repair. Audit will focus on paint, door frames, ac units, tiles, door handles and locks and overall condition. Audit results will be forwarded to the Quality Assurance Committee monthly x 3. (See Exhibit 13)</p> <p>F256</p> <p>Corrective measures for residents affected: The light bulb in the bathroom in 202 has been replaced and now provides adequate lighting.</p> <p>Identification of others with the potential to be affected: Facility residents have the potential to be affected.</p> <p>Facility Maintenance Director completed an audit of facility lighting to ensure adequate and comfortable lighting throughout the facility. (See Exhibit 14)</p>	08/22/2015	

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F 253	Continued From page 14 On 6/19/15 at 8:15 AM the Station 3 shower room still had the same brown stain on the floor. This finding was reviewed with E23 (Housekeeping/Laundry) on 6/19/15 at 9:15 AM. The facility failed to maintain a sanitary, orderly and comfortable interior. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM.	F 253	Measures to prevent Recurrence: Nurse Educator completed education with facility staff on the importance of informing maintenance immediately when lighting is not adequate. (See exhibit 3) The Maintenance Director that was in place during the survey is no longer employed at the facility. The facility currently has in place a preventative maintenance program called the		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to provide adequate lighting in 1 out of 22 sampled bathrooms. Findings include: On 6/16/15 at 11:54 AM and on 6/18/15 at 11:15 AM the bathroom light in room 202 was dim making it hard to see in the bathroom. Finding was reviewed with E10 (Director of Maintenance) on 6/18/15 during the environmental tour between 1:50 PM - 3:25 PM. Interview with E10 on 6/18/15 at 3:30 PM revealed that the facility used a computer program (Direct Supply TELS.) to track weekly and monthly inspections and maintenance.	F 256	Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to document findings during the rounds as well as the procedure for reporting identified concerns. (Exhibit 36, 37) Monitoring of Corrective Action: Facility Maintenance Director or designee will complete random audits of facility lighting to ensure that lighting is adequate and comfortable for facility residents. The sample size will be 5 patient care areas per audit and the sample areas will change with each audit. The random audits will occur on the following		

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F 256	Continued From page 15 On 6/19/15 at 8:50 AM, E10 provided a print out of logbook documentation for the weekly inspection done 6/12/15 by E11 (Maintenance Technician), that included room 202. The document recorded that the bathroom in room 202 had "fixtures clean and functioning correctly. No chips or rust". The facility failed to provide adequate lighting in a resident bathroom. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM.	F 256	schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 Corrective measures for residents affected: An ADL care plan has been developed for R109 to address the resident's specific ADL needs. An incontinence care plan has been developed for R81 to address the resident's incontinence needs. A care plan has been developed for R117 to address the resident's dialysis needs. Identification of others with the potential to be affected: Facility residents have the potential to be affected. Nurse Managers completed a facility wide audit to ensure facility residents have an ADL care plan in place that identifies the resident's current ADL	08/22/2015

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F 279	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R105, R81 and R117) out of 29 sampled residents the facility failed to develop a care plan for an identified need. Findings include:</p> <p>1. R105's quarterly MDS assessment, dated 4/13/15, stated the resident required extensive assistance with all ADLs, including personal hygiene.</p> <p>Review of R105's clinical record lacked evidence that a care plan was developed addressing ADLs.</p> <p>2. R81's quarterly MDS assessment, dated 3/28/15, stated the resident was occasionally incontinent of both bowel and bladder, having less than 7 episodes of incontinence in the review period.</p> <p>Review of R81's clinical record lacked evidence that a care plan was developed that addressed R81's incontinence.</p> <p>Findings were confirmed with E2 (DON) during an interview on 6/18/15 at approximately 2:30 PM.</p> <p>The facility failed to develop a care plan for R81 to address incontinence.</p> <p>3. Record review revealed that R117 had a port [catheter used for exchanging blood to and from the hemodialysis machine] in her right chest for hemodialysis (procedure that removes waste and extra fluid from the body) due to kidney failure.</p>	F 279	<p>status and assistance required for the resident. (See Exhibit 18)</p> <p>Nurse Managers completed a facility wide audit to ensure that facility residents have a care plan in place that identifies the resident's current incontinence or toileting needs and the plan of care to address/manage the resident's needs. (See Exhibit 18)</p> <p>Nurse Managers completed a facility wide audit to identify residents that require dialysis to ensure that a plan of care is in place to identify the resident's needs and to manage the identified needs. (See Exhibit 18)</p> <p>Measures to prevent Recurrence:</p> <p>Nurse Educator completed education with licensed nurses on the importance of developing individualized care plans that address resident specific needs. This education included information on how to initiate a care plan, updating the care plan with any change in condition and monitoring the care plan for appropriateness. (See Exhibit 3, Exhibit 16, Exhibit 17)</p> <p>Facility Unit Managers along with the MDS Coordinator will review resident care plans quarterly to ensure that care</p>		

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F 279	Continued From page 17 Physician's orders dated 5/27/15 stated, "Assess port to right upper chest every shift." Review of R117's clinical record revealed lack of a care plan for assessing the port. The facility failed to develop a care plan addressing R117's hemodialysis port. Findings were reviewed on 6/19/15 at 4:00 PM with E1 (NHA) and E2.	F 279	plans listed for each resident accurately reflect the resident's current needs, ADL status and Continence/Incontinence needs. Monitoring of Corrective Action: DON or designee will complete random audits of resident care plans to ensure that care plans are resident specific and capture the current needs of the resident. The sample size will be 5 residents, and the sample residents will change with each audit. . The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% success is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the Quality Assurance Committee. (See Exhibit 18)		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for 1 (R10) out of 29 stage 2 sampled residents, the facility failed to correctly administer medication. Findings include: 1a. Review of R10's medications revealed that R10 received an incorrect amount of Humalog U-100 Insulin on 6/11/15 at 6:18 AM. The sliding scale for blood sugar coverage ordered for R10 were: 151-200 (blood sugar) = 2 units (Insulin), 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-450= 12 units,	F 309	F309 Corrective measures for residents affected: There was no negative outcome to resident #R10. The expired medication was immediately discarded.	08/22/2015	

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F 309	Continued From page 18 451-500= 14 units, Call MD if less than 65 or greater than 500. R10 had a blood sugar of 253 on 6/11/15 at 6:18 AM and was given 4 units of Humalog U-100 Insulin. The correct dose should have been 6 units according to physician's orders. 1b. In addition, R10 received Humalog U-100 Insulin from an expired bottle on 6/13/15 at 4:01 PM, 6/14/15 at 6:03 AM, 6/14/15 at 4:09 PM, and on 6/15/ 2015 at 6:51 AM. On 6/18/15 at 2:30 PM, an interview was conducted with E7(UM). After reviewing the MAR and physician's orders, E7 (UM) confirmed findings that a bottle of Humalog U-100 Insulin was indeed expired and the insulin had been used for the administrations listed above. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit meeting at 4:00 PM on 6/19/15.	F 309	A medication error report was completed for resident R10. R10's physician and responsible party have been notified of the error. Identification of others with the potential to be affected: Facility residents have the potential to be affected. Nurse Managers completed a facility wide audit of medication carts and medication storage areas to ensure that medication are within date range and not expired. (See Exhibit 19) Nurse Managers completed a 30 day lookback for facility residents that receive sliding scale insulin coverage to ensure that the correct dose was administered per the physician order. (See Exhibit 18)		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	Measures to prevent Recurrence: Nurse Educator completed education with licensed nurses on the importance of checking the medication carts and medication room for expired medications at the start of every shift and the importance of removing and discarding any expired medication discovered. This education also included the need to check medication expiration dates prior to administering medications. (See Exhibit 3, Exhibit 20)		

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F 323	<p>Continued From page 19</p> <p>Based on observations, record reviews, interviews and review of facility documentation, it was determined that for three (R6, R17 and R7) out of 29 Stage 2 sampled residents, the facility failed to ensure that the resident's environment remained as free of accident hazards as was possible and residents received assistance devices to prevent accidents. For R6, the facility failed to ensure her bed side rail was secure and they failed to ensure her chair alarm was consistently placed on her wheelchair. For R17, the facility failed to ensure her bed side rails were secure. In addition, the facility failed to have a system in place to routinely check residents bed side rails for safety concerns. For R7, a loose electrical outlet was in reach of the resident when in bed. Additionally, there were observations of long rusted bolts on toilets and loose grab bar handrailings in bathrooms. Findings include:</p> <p>The facility's policy entitled "Bed Safety", last reviewed on 4/9/15, stated, "... Procedure: ... a. Inspect all bed frames, bed side rails, and mattresses quarterly as part of our regular safety program ...".</p> <p>1a. R6 was admitted to the facility on 8/30/14.</p> <p>6/15/15 at 12:03 PM - An observation revealed that R6's bed side rail was loose.</p> <p>6/18/15 at 8:36 AM - During an interview, E15 (RN) observed the unsecure bed side rail while R6 was laying in her bed and confirmed the finding. R6 stated during the observation that her bed side rail was loose.</p> <p>1b. 3/30/15 - A physician's order stated that R6 was required to have a bed and chair alarm and</p>	F 323	<p>Nurse Educator completed education with the licensed nurses on how to prevent medication errors. This education included education on the "5 rights" to avoid medication errors (right patient, right medication, right time, right dose, right route). This education also specifically addresses how to accurately give insulin using a sliding scale. (Exhibit 3, Exhibit 21, Exhibit 22, Exhibit 24, Exhibit 25)</p> <p>The facility has implemented a nightly check off tool to be completed by the night shift nursing staff to identify any expired or soon to expire medications on the med carts and in the medication storage rooms. This tool will be completed nightly and will be tracked through the facility Quality Assurance Program.</p> <p>One on one education and counseling has been completed with the nurse responsible for administering the incorrect dose of medication to R10.</p> <p>Monitoring of Corrective Action:</p> <p>DON or designee will complete random audits of facility medication carts and medication storage rooms to ensure that they are free from expired medications. The sample size will be all medication carts and medication storage rooms. The random audits will occur on the following schedule: Daily until 100% compliance is</p>	

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F 323	<p>Continued From page 20</p> <p>to check placement and function every shift.</p> <p>6/17/15 at 12:45 PM - An observation revealed that R6 was moving about in her wheelchair in the hallway without a chair alarm.</p> <p>6/17/15 at 2:27 PM - An observation revealed that R6 was participating in a social activity seated in her wheelchair in the dining room without a chair alarm.</p> <p>6/18/15 at 11:32 AM - An observation revealed that R6 was moving about in her wheelchair in the hallway without a chair alarm.</p> <p>6/18/15 at 11:55 AM - In an interview, E19 (CNA) stated that R6 required a chair alarm and bed alarm as safety devices and they must be checked every shift. E19 was asked if R6's chair alarm was currently on her chair. E19 and the surveyor immediately observed R6 in the dining room without the chair alarm. Findings were confirmed upon observation.</p> <p>Findings were reviewed with E2 (DON) on 6/19/15 at 2:35 PM. The facility failed to ensure that R6's environment remained as free of accident hazards as was possible and failed to ensure that R6 consistently received assistance devices to prevent accidents when R6's bed side rail was observed loose and R6 was observed multiple times in her wheelchair without a chair alarm.</p> <p>2. R17 was admitted to the facility on 10/13/08.</p> <p>6/15/15 at 2:27 PM - An observation revealed that R17's bed side rails were loose.</p>	F 323	<p>noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 19)</p> <p>DON or designee will complete random audits of residents receiving sliding scale coverage to ensure that the resident is free from medication errors. The sample will be 5 residents that receive sliding scale insulin coverage. The resident sample will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 23)</p> <p>DON or designee will complete random med pass observations to ensure that residents are free from medication errors. The sample will be 3 resident medication passes. The resident sample will change with each observation and medication pass</p>		

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F 323	<p>Continued From page 21</p> <p>6/18/15 at 8:15 AM - During an interview, E15 (RN) observed and confirmed the loose bilateral bed side rails while R17 was laying in her bed and immediately called E10 (Maintenance).</p> <p>6/18/15 at 8:24 AM - In an interview, E10 stated that the facility does not routinely check residents' bed side rails.</p> <p>6/19/15 at 2:35 PM - Findings were reviewed with E2. The facility failed to ensure that R17's environment remained as free of accident hazards as possible when her bed side rails were observed loose. In addition, the facility failed to have a system in place to routinely check residents bed side rails for safety concerns. On 6/15/15 during the initial tour between 7:40 AM - 8:30 AM and the environmental tour on 6/18/15 between 1:50 PM - 3:25 PM the following accident hazards were observed:</p> <p>3. Bolts on the bases of resident toilets used to hold the toilets to the floor were observed to be sticking up several inches without covers between 6/15/15 at 7:40 AM and 6/18/15 at 11:30 AM creating an accident hazard for residents if body contact was made. Additionally, some bolts were also rusty as follows:</p> <ul style="list-style-type: none"> * Shower room outside room 206 (Station 2) * Shower room outside room 214 (Memory Care unit) * Shower room on Station 3 (bolts rusty) * Room 301 - two bed room * Room 304 (bolts rusty).- three bed room * Room 305 (bolts rusty) - two bed room * Room 306 (bolts rusty) - three bed room * Room 307 (bolts rusty) - two bed room * Room 309 (bolts rusty) - two bed room * Room 310 - three bed room 	F 323	<p>times will alternate to ensure that each shift medication pass times are captured. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 23)</p> <p>F323</p> <p>Corrective measures for residents affected:</p> <p>There was no negative outcome to resident R6. Resident R6's side rails have been tightened. Resident R6 has demonstrated substantial non-compliance with her bed/chair alarm. Resident R6 is alert and oriented and chooses not to wear the alarm. Risk vs. Benefits of not wearing the alarm has been explained to the resident. Resident states an understanding of this information and chooses to have the bed/chair alarm discontinued. Resident R6's physician has been notified and a physician's order has been obtained to d/c the bed/chair alarm. Resident R8's care plan has been updated to reflect this information.</p> <p>There was no negative outcome to resident R17. The side rails on resident R17's bed have been tightened.</p>	08/22/2015
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F 323	<p>Continued From page 22</p> <p>* Room 315 (bolts rusty) - two bed room</p> <p>4. Between 6/15/15 at 7:40 AM and 6/18/15 at 11:30 AM the following bathroom grab bars, toilet seats and sinks were found to be loose:</p> <ul style="list-style-type: none"> * Room 107 grab bar and toilet seat - shared by two single rooms * Room 305 sink separated from wall and loose - two bed room * Room 306 grab bar - three bed room * Room 309 grab bar on wall closest to door and sink - two bed room * Room 315 grab bar - two bed room <p>* Shower room outside room 206 (Station 2) grab bar by shower area</p> <p>* Shower room outside room 214 (Memory Care unit) two grab bars by shower area</p> <p>* Shower room (Station 3) sink extremely loose from the wall E10 (Maintenance Director) contacted and E11 (Maintenance Technician) to immediately tighten the sink to the wall.</p> <p>5. On 6/16/15 at 10:21 AM a double electric outlet box allowing for four plugged items (protruding 3-4 inches from the wall) was loose. While in bed, R7 was able to touch this outlet box.</p> <p>Findings were reviewed with E10 on 6/18/15 during the environmental tour conducted between 1:50 PM - 3:25 PM.</p> <p>On 6/19/15 at 9:00 AM R7 was observed in bed with the head of her bed up around 45 degrees. R7's raised bed side rail was pressing against the left side of the electric outlet box which was pulled away from the wall.</p>	F 323	<p>There was no negative outcome to resident R7. The outlet box located in R7's room has been repaired.</p> <p>The exposed toilet bolts have been cut down and covers have been placed on them. The bolts identified as "rusty" have been replaced and covers have been placed on them.</p> <p>The sinks identified as loose (305, 309, Station 3 shower room) have been repaired and are now secured to the wall.</p> <p>The grab bars identified as loose (107, 306, 309, 315, Station 2 shower room and Memory care shower room) have all been tightened and are now secure.</p> <p>The toilet seat in room 107 has been tightened and is no longer loose.</p> <p>Identification of others with the potential to be affected:</p> <p>Facility Residents have the potential to be affected.</p> <p>Nurse Managers completed facility wide audits to identify facility residents with an ordered bed/chair alarm to ensure that the devices were present and in place per the plan of care and physicians order. (Exhibit 18)</p>	

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F 323	Continued From page 23 The facility failed to ensure the residents' environment remained as free from accident hazards as possible.	F 323	Facility Maintenance Director completed a facility wide audit to identify residents with side rails to ensure that side rails are secure and not loose. (Exhibit 26)	
F 356 SS=C	Findings were reviewed with E1 (NHA) and E2 on 6/19/15 at 4:00 PM. 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	Facility Maintenance Director completed a facility wide audit to identify grab bars located in the facility to ensure that grab bars are secure and not loose. (Exhibit 26) Facility Maintenance Director completed a facility wide audit of facility sinks to ensure that the sinks are secured appropriately to the wall. (Exhibit 26) Facility Maintenance Director completed a facility Wide audit of facility bathrooms to identify and repair toilet bolts that require cutting and covering and to ensure that toilet seats are appropriately secured. (Exhibit 26) Facility Maintenance Director completed a facility wide audit to ensure that all outlets are secured and not loose. (Exhibit 26) Measures to prevent Recurrence: Nurse Educator completed an in-service with facility staff on the importance of ensuring ordered safety devices are present on the resident as ordered. The education also included the need to report and document non-compliance with ordered safety devices, the resident's right to refuse and how to proceed when a resident refuses to wear safety devices. (Exhibit 3)	

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F 356	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for 5 out of 5 days, the facility failed to post the following information in a prominent place that was readily accessible to residents and visitors on a daily basis: the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and the resident census. Findings include:</p> <p>From 6/15/15 through 6/19/15, observations were made throughout the facility that revealed the daily staff posting lacked evidence of the total number and the actual hours worked by licensed and unlicensed nursing staff and the resident census.</p> <p>In an interview on 6/19/15 at 2:35 PM, E2 (DON) confirmed the findings.</p> <p>The facility failed to ensure the posted daily staffing included the resident census and the total number and actual hours worked by licensed and unlicensed staff from 6/15/15 through 6/19/15.</p>	F 356	<p>Nurse Educator provided education to facility staff on the importance of ensuring that the resident's environment is free from accident hazards. This education included the need to immediately report to the maintenance department when there is a potential accident hazard, such as a loose sink, loose bed rail, or loose toilet seat. The education also focused on preventing accident hazards by ensuring that the bed is away from the wall and outlets prior to raising or lowering the bed to minimize the risk of the outlet box being separated from the wall. Staff received education on the need to immediately report to maintenance if the outlet box does separate from the wall. (Exhibit 3)</p> <p>The Maintenance Director that was in place during the survey is no longer employed at the facility. The facility currently has in place a preventative maintenance program called the Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to document findings during the rounds as</p>	
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371		

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F 371	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during breakfast and the kitchen tour, and interviews, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include:</p> <ol style="list-style-type: none"> On 6/15/15 at 7:50 AM, E24 (CNA) delivered a meal tray to R35. E24 was observed touching R35's breakfast sandwich with a bare hand while cutting the sandwich in half. On 6/16/15 from approximately 10:00 AM to 11:52 AM during the kitchen tour with E16 (FSD) and on 6/16/15 from approximately 12:00 PM to 12:35 PM with E1 (NHA) the following were observed: <ul style="list-style-type: none"> An observation in the walk-in refrigerator revealed a box of eggs stored above ready-to-eat food, butter and creamer. Findings were acknowledged with E16. The facility failed to ensure that food was protected from cross contamination. The walk-in refrigerator revealed undated containers of lasagna and cooked vegetables. Findings were confirmed immediately upon observation with E16. The facility failed to ensure that prepared food was dated. An observation in the dry storage area revealed shelving constructed out of chipped wood 	F 371	<p>well as the procedure for reporting identified concerns. (Exhibit 36, 37)</p> <p>Monitoring of Corrective Action:</p> <p>DON or designee will complete random audits to ensure that residents with ordered bed/chair alarms have the device in place per the physicians order and plan of care. The sample size will be 5 residents with bed/chair alarms ordered. The resident sample will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 27)</p> <p>Facility Administrator will complete random audits to ensure that the facility preventative maintenance program is in place and being followed. Audits will focus on ensuring that bed rails, grab bars, sinks, outlet boxes and toilet seats are secured. The sample size will be 5 patient care areas per audit. The areas audited will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for</p>	
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F 371	Continued From page 26 rendering it difficult to clean. Finding was acknowledged with E16. The facility failed to ensure the shelving in the dry storage area had a cleanable surface. - An observation on the tray line in the kitchen revealed clean utensils being stored improperly. Findings were acknowledged with E16. The facility failed to invert clean utensils in the kitchen. - E27 (dietary staff) was observed emptying the dishwasher and handling sanitized utensils on the food- and lip-contact surfaces with his bare hands. Findings were acknowledged with E16. The facility failed to ensure that clean and sanitized utensils were handled to prevent contamination of the food- and lip-contact surface. - Observation of a wall by the dishwasher and a wall by the stove revealed unsealed wood as the surface and they were not easily cleanable. Findings were reviewed with E1. The facility failed to ensure that the surfaces of two walls in the kitchen were smooth and easily cleanable. - Observations of the walls next to the dishwasher and next to the stove revealed gaps greater than 1 millimeter between the air conditioning (a/c) units and the walls. Findings were reviewed with E1. The facility failed to ensure that openings between the air conditioning units and walls were sealed properly. - Observation of the a/c unit next to the stove at 11:25 AM revealed cool air blowing towards the food-contact surfaces, equipment, and/or utensils. Observation of the a/c unit next to the stove at 1:00 PM revealed cool air blowing towards food on the steam table. Findings were reviewed with E1. The facility failed to prevent the a/c unit by the stove from causing contamination	F 371	three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 13) F356 Corrective measures for residents affected: The facility has implemented a daily staffing sheet tool that is now posted on every unit. The Staffing Sheet identifies the facility name, date, census, total RN hours, total LPN hours and total CNA hours. The sheet also identified the nurse to resident ratio and the CNA to resident ratio per shift. The staffing sheet has been placed in a clearly visible place on each unit where it can be easily viewed by residents, staff and visitors. (See Exhibit 28) Identification of others with the potential to be affected: Facility Residents have the potential to be affected. Measures to prevent Recurrence: Nurse educator provided education to facility staff on the importance of completing and posting the daily staffing sheet in the designated visible place on the	08/22/2015	

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F 371	Continued From page 27 of food, food-contact surfaces, equipment, and/or utensils. - Observations revealed openings between the a/c unit and the wall next to the dishwasher and between the a/c unit and the wall next to the stove. Findings were reviewed with E1. While in the kitchen reviewing findings with E1, she swatted a fly away from her. The facility failed to ensure the openings between the a/c units and walls next to the dishwasher and stove were protected against the entry of insects and rodents from the outside. - Observation of the handwashing sink in the kitchen revealed the absence of a visible sign notifying food employees to wash their hands. Findings were reviewed with E1. The facility failed to post a visible sign notifying food employees to wash their hands. Findings were reviewed with E1 and E2 (DON) during the informational meeting on 6/19/15 at approximately 4 PM.	F 371	unit daily. Education was also provided to the facility nurses on how to accurately complete the form, how to calculate RN, LPN and CNA hours and how to calculate the nurse to resident ratio and the CNA to resident ratio. (See Exhibit 3) Monitoring of Corrective Action: DON or designee will complete random audits to ensure that the daily staffing sheet is completed accurately and correctly and is posted in the designated, clearly visible place on the unit where it can be easily viewed by residents, visitors and staff. Audit findings will be reported to the facility Quality Assurance Committee for a minimum of monthly x 3. (See Exhibit 29)		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F371 Corrective measures for residents affected: There was no negative outcome to resident R35. The ready to eat food located under the box of eggs was discarded along with the undated containers of lasagna and vegetables. The shelving located in the dry pantry has been repaired and is now an easily cleanable surface. The utensils identified as improperly stored were removed from the tray line and were washed prior to use.	08/22/2015	

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NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940
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F 431	<p>Continued From page 28</p> <p>instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to remove expired medications from 2 out of 3 medication storage areas to facilitate the safe administration of medications. Findings include:</p> <p>cross refer F309</p> <p>1. On 6/15/15 at 2:45 PM - One opened bottle of Humalog U-100 Insulin belonging to R10 was found when performing the medication storage review on Unit 1. R10 received five doses of Insulin after the expiration date of 6/13/15. An interview on 6/15/15 at 2:45 PM with E6 (LPN) and E7 (UM) confirmed the medication was</p>	F 431	<p>The utensils that were improperly removed from the dishwasher were re-washed prior to use.</p> <p>The walls by the dishwasher and stove have been repaired and are now an easily cleanable surface.</p> <p>The gaps located between the air-conditioning units and the walls have been sealed.</p> <p>The Air-conditioning unit next to the stove has been moved to an area that does not allow air to blow towards the cooking surface, utensils and steam table.</p> <p>The opening between the air-conditioning units and the walls has been sealed and does not allow for the entry of insects.</p> <p>A handwashing sign that reminds employees to wash their hands has been placed in a visible location by the handwashing sink.</p> <p>Identification of others with the potential to be affected: Facility Residents have the potential to be affected.</p> <p>Facility Administrator completed an audit of the facility walk in refrigerator to ensure that food was protected from cross contamination. (Exhibit 31)</p>	

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F 431	Continued From page 29 expired.	F 431	Facility Administrator completed an audit of the facility walk in refrigerator to ensure that all food items are dated. (Exhibit 31)	
F 463 SS=D	<p>2. On 6/19/15 at 11:10 AM on Unit 3, Cart 2- found 11 tablets of Alprazolam 0.25 mg (an anti-anxiety medication) were expired as of 4/2015. An interview on 6/19/15 at 11:30 AM with E8 (LPN) on confirmed finding.</p> <p>These findings were confirmed with E1 (NHA) and E2 (DON) during the exit interview at 4:00 PM on 6/19/15.</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to receive resident calls from 2 (room 301 and 306) out of 22 sampled bathrooms. Findings include:</p> <p>On 6/15/15 at 11:08 AM the bathroom call light in room 306 sounded, but did not light up outside of the room. On 6/15/15 at 11:15 AM, E14 (CNA) confirmed the finding.</p> <p>On 6/16/15 at 10:21 AM the bathroom call light in room 301 lit up in the nursing station on the dementia unit (on the other side of locked doors) so it was not visible in the unit where the resident resided.</p>	F 463	<p>Facility Administrator completed an audit of the kitchen for the following: to ensure that surfaces are easily cleanable, to ensure that there are no gaps located between the air-conditioning units and the walls, to ensure that the air-conditioning units are well sealed to prevent the entry of insects and to ensure proper storage and handling of utensils. (Exhibit 31)</p> <p>Measures to prevent Recurrence:</p> <p>The Maintenance Director that was in place during the survey is no longer employed at the facility.</p> <p>The facility currently has in place a preventative maintenance program called the Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to</p>	

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F 463	Continued From page 30 Findings were reviewed with E10 (Maintenance Director) during the environmental tour on 6/18/15 between 1:50 PM - 3:25 PM. E10 stated the light in 301 "didn't transfer" when the dementia unit was created and that he would call the vendor to correct this issue. The facility failed to ensure that two call lights illuminated in the area in which the residents resided.	F 463	document findings during the rounds as well as the procedure for reporting identified concerns. (Exhibit 36, 37) The Dietary Manager that was in place during the survey is no longer employed by the facility. The facility Administrator has taken responsibility of the kitchen until such time that a Certified Dietary Manager can be hired.		
F 469 SS=F	Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM. 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain an effective pest control program for flies. Flies were observed throughout the survey directly on residents, in resident rooms and throughout the facility. Findings include: A. The Pest Elimination Services Agreement with Ecolab dated 9/27/09 included (a) monthly large fly program during May, June, July, August, September and October, (b) expanded large fly pest reporting and (c) twice monthly cockroach and rodent program. Black flying pest eliminators were mounted every 10-15 feet on the outside of	F 469	Nurse Educator completed education with the dietary staff on infection control practices. This included how to appropriately handle and secure utensils, the need for smooth easily cleanable surfaces, the need to date food placed in the refrigerator and how to store food properly without the potential of cross contamination. (Exhibit 32) Nurse Educator provided education to facility staff on the importance of infection control practices as they pertain to handling food. The in-service included the need to wash your hands and wear gloves if the employee must touch the resident's food in any way.(Exhibit 3) Monitoring of Corrective Action: DON or designee will complete random audits to ensure that infection control practices are being followed by staff members while serving food. The dining observation will include audits that ensure that staff members wash their hands and use gloves prior to touching the resident's food.		

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F 469	Continued From page 31 the facility and several wall-mounted Ecolab flying pest eliminator devices (bug lights) were noted inside the facility. 1. On 6/15/15 at 8:40 AM sunlight was visible through a 6-8 inch long gap at the bottom right of the exit door in the ice machine room. 2. On 6/15/15 at 11:22 AM food debris was observed on the floor of R106's room, especially near the bed. Some food was smashed into the floor. A live fly was flying around the room. 3. On 6/15/15 at 11:47 AM a live fly was observed on the back of R106's left hand while the resident was propelling himself in the hallway. 4. On 6/15/15 at 11:54 AM a live fly was observed in R93's bathroom. 5A. On 6/15/15 at 11:54 AM food debris was observed on the right side of R75's bed along with a full trash can and a dried spill on the floor next to the trash can. Two live flies were flying around the resident's room. B. On 6/15/15 at 2:06 PM Ecolab Pest Elimination Division completed their cockroach, rodent, large fly and expanded large fly pest reporting service at the facility. 6. On 6/15/15 at 12:09 AM crumbs were observed on the floor by R6's bed and a live fly was flying in the room. 7. On 6/15/15 at 12:14 PM R28's floor had a dried spill and a live fly was flying in the room.	F 469	The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. Audit results will be forwarded to the facility Quality Assurance Committee.(Exhibit 30) Facility Administrator or designee will complete random audits of the facilities walk in refrigerator to ensure that food is being stored properly without the risk of cross contamination and that food items stored in the refrigerator have been dated. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 31)		

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F 469	Continued From page 32 8. On 6/15/15 at 2:34 PM three live flies were seen on the sheet covering R19 at the same time. This resident was unable to move or speak. 9. On 6/15/15 at 2:55 PM live flies were seen in R71's room. R71 showed the surveyor a fly swatter that she stated was given to her by staff when she was admitted to the facility. R71 also stated that her roommate has her own fly swatter and when her roommate is in the room, the roommate kills the flies. 10. On 6/16/15 at 10:01 AM a fly was observed flying in the room during an interview with R105. 11. On 6/18/15 at 11:30 AM the Station 3 shower floor had brown material approximately 2 inches wide and 5 inches long. On 6/19/15 at 8:15 AM the same brown material remained on the shower room floor. Finding was confirmed with E23 (Director of Housekeeping/ Laundry) on 6/19/15 at 9:15 AM. On 6/16/15 Ecolab returned to spray the facility for ants and they completed the task at 10:53 AM. The customer service report from Ecolab stated, "food debris found on the floor" in "patient/guest rooms - interior" with a recommended action "please clean regularly." The facility failed to maintain an effective pest control program for flies and to take necessary measures to deter the entry of other pests into the building. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/19/15 at 4:00 PM.	F 469	Facility LNHA or designee will complete random audits of the physical plant of the kitchen to ensure that kitchen surfaces are smooth and easily cleanable, that utensils are stored properly, that the handwashing sign is located near the handwashing sink in a clearly visible location, that there are no gaps in between the air-conditioning units and the walls and that the kitchen air-conditioning units are not blowing air on and potentially contaminating any food, food-contact surfaces, equipment and/or utensils. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. Findings will be reported to the facility Quality Assurance Committee. (Exhibit 31) Facility Administrator or designee will complete random audits of facility staff emptying the dishwasher to ensure that they are handling utensils in an appropriate way that upholds current infection control standards. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week	
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	<p>Continued From page 33</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for 3 (R6, R105 and R115) out of 29 Stage 2 sampled residents, the facility failed to maintain accurate and complete clinical records. Findings include:</p> <p>1. R115's clinical record included the following;</p> <p>5/11/15 - RD recommended double portion breakfast for a recent weight loss.</p> <p>5/11/15 - Care plan was updated for initiation of large portions with breakfast in addition to the super cereal that was already in place.</p> <p>5/18/15 - RD noted that large portions were implemented and there was 100% meal consumption.</p>	F 514	<p>until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. Findings will be reported to the facility Quality Assurance Committee.(Exhibit 31)</p> <p>F431</p> <p>Corrective measures for residents affected: There was no negative outcome to resident R10.</p> <p>The expired medications were immediately removed and discarded.</p> <p>A medication error report was completed for resident R10. R10's physician and responsible party have been notified of the error.</p> <p>Identification of others with the potential to be affected: Facility Residents have the potential to be affected.</p> <p>Facility Nurse Managers completed an audit of facility medication carts and medication storage rooms to ensure that all medications in house are within the acceptable date range and are not expired. (Exhibit 19)</p>	08/22/2015
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F 514	<p>Continued From page 34</p> <p>Interviews on 6/18/15 at 3:54 PM with E2 (DON) and at 5:23 PM with E7 (RN) revealed that the original request to have large portions was never reviewed with the doctor and never implemented. It was further revealed that the doctor was consulted today and the doctor did not want to add large portions due to R115's diabetes.</p> <p>The clinical record noted in both the care plan and the dietary notes that the resident had an intervention of large portions at breakfast when in fact the approach was never approved by the physician.</p> <p>2. R105 had a physician's order dated 2/9/15 for a peanut butter and jelly sandwich, milk, and a banana with the evening snack.</p> <p>Review of the May 2015 and June 2015 POS's lacked the order for the evening snack.</p> <p>Review of the electronic clinical record charting system revealed no documentation of the administration or consumption of the evening snack.</p> <p>During an interview on 6/18/15 at 5:49 PM with E18 (RN) and E17 (CNA) , they stated that the sandwich, milk and banana were delivered from the kitchen every evening and the resident always eats it.</p> <p>During an interview on 6/19/15 at 9:01 AM with E3 (MDS Coordinator), she confirmed that the evening snack was not on the POS or in the CNA documentation system in the clinical record.</p> <p>During an interview on 6/19/15 at 10:20 AM with E16 (FSD), she stated the evening snack order</p>	F 514	<p>Measures to prevent Recurrence:</p> <p>Nurse Educator provided education to facility licensed nursing staff on the importance of checking the medication cart and medication storage rooms for expired medications at the start of every shift and the importance of removing and discarding expired medications when they are discovered. The education also included the need to check the medications expiration date prior to administering it. (Exhibit 3, Exhibit 20)</p> <p>The facility has implemented a nightly check off tool to be completed by the night shift nursing staff to identify any expired or soon to expire medications on the med carts and in the medication storage rooms. This tool will be completed nightly and will be tracked through the facility Quality Assurance Program.</p> <p>Monitoring of Corrective Action:</p> <p>DON or designee will complete random audits of facility medication carts and medication storage rooms to ensure that they are free from expired medications. The sample size will be all medication carts and medication storage rooms. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for</p>	
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F 514	<p>Continued From page 35</p> <p>was in the dietary computer system and it was delivered nightly.</p> <p>Although according to staff interview R105 received his evening snack, the facility failed to ensure the clinical record included the current physician order and staff documentation of the snack.</p> <p>3. A physician's history and physical, dated 3/31/15, revealed that R6 was allergic to shellfish, Glucophage (medication for high blood sugar) and contrast dye (medical substance used in diagnostic tests).</p> <p>Review of R6's June 2015 POS revealed a lack of evidence of allergies.</p> <p>Review of R6's June 2015 MAR revealed a lack of evidence of allergies.</p> <p>In an interview on 6/19/15 at 2:35 PM, E2 (DON) confirmed the findings. The facility failed to ensure that R6's clinical record was complete when her allergies were not listed on the June 2015 POS and the June 2015 MAR.</p> <p>Findings were reviewed with E1 (NHA) and E2 on 6/19/15 at 4:00 PM.</p>	F 514	<p>three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 19)</p> <p>DON or designee will complete random med pass observations to ensure that residents are free from medication errors. The sample will be 3 resident medication passes. The resident sample will change with each observation and medication pass times will alternate to ensure that each shift medication pass times are captured. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 23)</p> <p>F463</p> <p>Corrective Measures for Residents Affected:</p> <p>The call bell in room 306's bathroom has been repaired and now lights up outside of the resident's room.</p>	8/22/2015	

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			<p>The call bell for room 301 has been repaired and lights on the appropriate nurse's station.</p> <p>Identification of others with the potential to be affected:</p> <p>Facility Residents have the potential to be affected.</p> <p>Facility Maintenance Director completed an audit of facility call bells to ensure that call bells light up appropriately and show as lit on the appropriate nurse's station. (Exhibit 33)</p> <p>Measures to Prevent Recurrence:</p> <p>Facility Nurse Educator completed education with facility staff on the importance of reporting maintenance issues in a timely manner to include malfunctioning call bells. (Exhibit 3)</p> <p>The Maintenance Director that was in place during the survey is no longer employed at the facility. The facility currently has in place a preventative maintenance program called the Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will</p>		

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			<p>be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to document findings during the rounds as well as the procedure for reporting identified concerns. (Exhibit 36, 37)</p> <p>Monitoring of Corrective Action: Facility Administrator or designee will complete random audits to ensure that facility call bells are functioning appropriately. The sample size will be 5 patient care areas per audit and the sample areas will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Administrator or designee will complete random audits of the physical plant to ensure that the physical plant is in good repair. Audit will focus on paint, door frames, ac units, tiles, door handles and locks and overall condition. Audit results will be forwarded to the Quality Assurance Committee monthly x 3. Audit results will be forward to the facility Quality Assurance Committee. (Exhibit 33)</p>		

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			<p>F469</p> <p>Corrective measures for residents affected: There was no negative outcome to residents affected.</p> <p>The gap along the exterior door by the ice machine has been corrected.</p> <p>Facility will continue to use EcoLab for its pest control program. The facility has a contract with the vendor for pest elimination services to include a monthly large fly program during the months of May, June, July, August, September and October. The facility will continue to utilize the recommended equipment and measures from the pest control vendor.</p> <p>Identification of others with the potential to be affected: Facility Residents have the potential to be affected.</p> <p>Facility Maintenance Director completed an audit of the physical plant to identify any areas to the exterior that have the potential to allow flies in to the building to ensure that the facility has taken all measures to deter the entry of flies into the building. (Exhibit 13, Exhibit 35)</p> <p>Facility Director of Housekeeping conducted an audit of the physical plant to ensure that attractants such as food crumbs and spills are adequately being addressed in order to prevent flies. (Exhibit 13)</p>	8/22/2015

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			<p>Measures to prevent Recurrence: The Maintenance Director that was in place during the survey is no longer employed at the facility. The facility currently has in place a preventative maintenance program called the Tels program. This program provides a scheduled preventative maintenance program that addresses issues such as the ones identified during the survey. The current Maintenance Director is well versed on the program and how to successfully incorporate a preventative maintenance program in to the daily operations. (Exhibit 35)The facility has also implemented Ambassador Rounds that will be conducted by facility Department Heads for a minimum of 5 days a week. The policy for the rounds has been developed and Department Heads have received education on the policy and the tool developed to document findings during the rounds as well as the procedure for reporting identified concerns. (Exhibit 36, 37)</p> <p>Nurse Educator provided education to facility staff on the importance of maintaining a clean environment. This education included the need to clean up food spills as they occur, keeping urinals and bedside commodes empty and clean and ensuring that there are no attractants for the flies. The education also focused on the need to report to the maintenance department when a potential entrance in to the facility form the outside, such as a gap in the door or ac unit, is discovered. (Exhibit 3)</p>	

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			<p>Monitoring of Corrective Action:</p> <p>Facility Administrator or designee will complete random audits of the physical plant to ensure that there are no gaps on exterior doors, windows or ac units that have the potential to serve as an entrance for flies in the building. The audit will also focus on the cleanliness of the physical plant to ensure attractants such as food spills are cleaned up promptly. The sample size will be 5 patient care areas per audit and the sample areas will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 13)</p> <p>F514</p> <p>Corrective measures for residents affected: There was no negative outcome to residents affected.</p> <p>The physician for R115 was contacted about the dietary recommendation and did not feel that the recommendation was appropriate. The facility will continue to monitor the resident's weight.</p>		8/22/2015

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			<p>Resident R105 was receiving the supplements that were recommended by the dietitian. A physicians order was added to the residents POS to ensure the clinical record included the physicians order and staff documentation of the supplement.</p> <p>The allergy list for resident R6 has been updated to reflect the resident's current allergies. This information appears on the residents face sheet, POS and MAR.</p> <p>Identification of others with the potential to be affected: Facility Residents have the potential to be affected.</p> <p>Facility Nurse Managers completed an audit of dietary recommendations made for facility residents within the last 90 days to ensure that the physician was made aware of the recommendation, the kitchen is aware of the recommendation if it was approved by the physician and that there is an associated physicians order for the recommendation. (Exhibit 18)</p> <p>Facility Nurse Managers conducted a house wide audit to ensure that resident allergies are listed on the face sheet, POS and MAR. (Exhibit 18)</p> <p>Measures to prevent Recurrence: Facility Nurse Educator provided education to licensed nurses on the importance of reviewing dietary recommendations with the physician, writing a physician order for approved recommendations and</p>		

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			<p>communicating any approved dietary recommendations to the kitchen. (Exhibit 3, Exhibit 36)</p> <p>Facility Nurse Educator provided education to licensed nurses on the importance of accurately documenting the resident's allergies in the medical record. Staff members received education on the appropriate process of entering the allergies in the medical record to allow it to appropriately show on the face sheet, MAR and POS. (Exhibit 3)</p> <p>Facility Dietitian will now be contacting the PCP and writing verbal orders for recommendations on the physician order sheets in order to prevent any delay with dietary recommendations.</p> <p>Facility Unit Managers will be completing new admission chart audits within 72 hours of admission to ensure that resident allergies show on the POS, MAR and Face sheet.</p> <p>The facility has contracted a new EMAR vendor, this transition is scheduled to occur 09/21/2015.</p> <p>Monitoring of Corrective Action:</p> <p>DON or designee will complete random audits to ensure that dietary recommendations are reviewed with the physician in a timely manner, that a physician order is obtained and</p>	

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			<p>documented for approved recommendations. The sample size will be 5 patients per audit and the sample residents will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 18)</p> <p>DON or designee will complete random audits to ensure that resident allergies are accurately documented. The sample size will be 5 residents per audit and the sample residents will change with each audit. The random audits will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted for three consecutive evaluations, then monthly until such time that 100% compliance is noted for three consecutive</p>		

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			evaluations. Audit results will be forwarded to the facility Quality Assurance Committee in the medical record. (Exhibit 18)		



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STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center

DATE SURVEY COMPLETED: June 23, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced annual survey was conducted at this facility from June 15, 2015 through June 23, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 93. The survey sample totaled twenty nine (29).

Abbreviations/Definitions used in this 2567 are as follows:

- NHA- Nursing Home Administrator;
- DON - Director of Nursing;
- RN - Registered Nurse;
- LPN - Licensed Practical Nurse;
- UM- Unit Manager;
- MD - Medical Doctor;
- RNAC- Registered Nurse Assessment Coordinator;
- MDS - Minimum Data Set (standardized assessment forms used in nursing homes);
- CNA - Certified Nurse's Aide;
- FSD- Food Service Director;
- RD- Registered Dietitian;
- ADLs - Activities of Daily Living, such as bathing and dressing;

Delmar Nursing and Rehabilitation Center's plan of correction for the deficiencies noted during our annual survey ending June 23, 2015 is not an admission to the deficiencies, but our desire to show compliance with all Federal and State regulations.

1

Provider's Signature

Title

D.O.N.

Date

8/3/15



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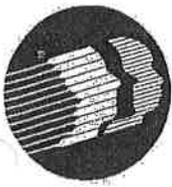
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><u>mg</u>- milligrams; <u>PT</u>- physical therapy; <u>Hoyer lift</u>-device to aid in transfer of residents between surfaces; <u>FSBS</u> - finger stick blood sugar; <u>MAR</u> - Medication Administration Record; <u>Urinary incontinence</u>- inability to prevent accidental leakage of urine from bladder; <u>Urinary continence</u> - ability to prevent accidental leakage of urine from bladder; <u>Sliding scale</u> - Physician's orders to give insulin injections based on FSBS reading; <u>POS</u> - Physician's Order Sheet; <u>Insulin</u> - medication injected under the skin to lower blood sugar level; <u>Air gap</u> - unobstructed space that prevents drained water from backing up into the sink and/or dishwasher, possibly contaminating dishes; <u>Invert</u> - turn upside down; <u>Lucite</u> - solid transparent plastic; <u>Millimeter</u> - unit of measurement.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory</p>	<p>Please refer to §1164</p>	<p>08/22/2015</p>
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<p>3201.7.0 3201.7.5</p>	<p>requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross refer to the CMS-2567-L survey exit date 6/19/15, F159, F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514.</p> <p>Plant, Equipment and Physical Environment</p> <p>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</p> <p>2-102.12 Certified Food Protection Manager. (A) At least one employee, the person in charge at the time of inspection, shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program. This requirement is not met as evidenced by:</p> <p>Based on an interview, it was determined that the facility failed to have a certified food protection manager. Findings include:</p> <p>6/16/15 at 10:00 AM – In an interview, E16</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	<p>08/22/2015</p>
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3201. 3-
302.11

(FSD) stated that his certification as a food protection manager expired in 2012.

6/16/15 at 12:50 PM – Findings were reviewed with E1 (NHA). The facility failed to have a certified food protection manager.

Packaged and Unpackaged Food – Separation, Packaging, and Segregation.

(A) Food shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal foods during storage, preparation, holding, and display from: (a) Raw ready-to-eat food including other raw animal food such as fish for sushi or molluscan shellfish, or other raw ready-to-eat food such as fruits and vegetables, and (b) Cooked ready-to-eat food; (c) Frozen, commercially processed and packaged raw animal food may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food.

This requirement is not met as evidenced by:

Based on observation and interview, it was determined that the facility failed to ensure that food was protected from cross contamination. Findings include:

6/16/15 at 10:48 AM – An observation in the walk-in refrigerator revealed a box of eggs stored above ready-to-eat food, butter and creamer.

Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514

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3201.3-
501.17

6/16/15 at 10:52 AM – Findings were acknowledged with E16 (FSD). The facility failed to ensure that food was protected from cross contamination.
Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking.

(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. (B) Except as specified in (D) - (F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a

Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514

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	<p>manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) ingredient or a portion of a refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other</p>		
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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: Delmar Nursing and Rehabilitation Center

DATE SURVEY COMPLETED: June 23, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p>effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. (E) Paragraphs (A) and (B) of this section do not apply to individual meal portions served or repackaged for sale from a bulk container upon a consumer's request. (F) Paragraph (B) of this section does not apply to the following FOODS prepared and PACKAGED by a FOOD PROCESSING PLANT inspected by a REGULATORY AUTHORITY: (1) Deli salads, such as ham salad, seafood salad, chicken salad, egg salad, pasta salad, potato salad, and macaroni salad, manufactured in accordance with 21 CFR 110 Current good manufacturing practice in manufacturing, packing, or holding human food; (2) Hard cheeses containing not more than 39% moisture as defined in 21 CFR 133 Cheeses and related cheese products, such as cheddar, gruyere, parmesan and reggiano, and romano; (3) Semi-soft cheeses containing more than 39% moisture, but not more than 50% moisture, as defined in 21 CFR 133 Cheeses and related cheese products, such as blue, edam, gorgonzola, gouda, and monterey jack; (4) Cultured dairy products as defined in 21 CFR 131 Milk and cream, such as yogurt, sour cream, and buttermilk; (5) Preserved FISH products, such as pickled herring and dried or salted cod, and other acidified FISH products defined in 21 CFR 114 Acidified foods; (6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original</p>		
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<p>3201. 4-202.16</p>	<p>CASING on the product; and (7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers.</p> <p>This requirement is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that prepared food was dated. Findings include:</p> <p>6/16/15 at 10:40 AM – An observation of the walk-in refrigerator revealed undated containers of lasagna and cooked vegetables. Findings were confirmed immediately upon observation with E16 (FSD).</p> <p>The facility failed to ensure prepared food was dated.</p> <p>Nonfood-Contact Surfaces. Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to ensure the shelving in the dry storage area had a cleanable surface. Findings include:</p> <p>6/16/15 at 12:00 PM – An observation in the dry storage area revealed shelving constructed out of chipped wood rendering it</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	<p>08/22/2015</p>
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3201. 4-903.11	<p>difficult to clean.</p> <p>6/16/15 at 12:01 PM – Finding was acknowledged with E16 (FSD). The facility failed to ensure the shelving in the dry storage area had a cleanable surface.</p> <p>Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (2) Covered or inverted. This requirement is not met as evidenced by: Based on observation, it was determined that the facility failed to invert clean utensils in the kitchen. Findings include:</p> <p>6/16/15 at 11:50 AM – An observation on the tray line in the kitchen revealed clean utensils being stored improperly.</p>		
3201. 4-904.11	<p>6/16/15 at 11:52 AM – Findings were acknowledged with E16 (FSD). The facility failed to invert clean utensils in the kitchen.</p> <p>Kitchenware and Tableware. (A) Single-service and single-use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food- and lip-contact surfaces is prevented. This requirement is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that clean and sanitized utensils were handled to prevent contamination of the food-</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	08/22/2015

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201.5-
203.14

and lip-contact surfaces. Findings include:

6/16/15 at 11:35 AM – An observation in the kitchen revealed E27 (dietary staff) emptying the dishwasher and handling sanitized utensils on the food- and lip-contact surfaces with his bare hands.

6/16/15 at 11:50 AM – An observation in the kitchen revealed E27 at the tray line and handling clean utensils on the food- and lip-contact surfaces with his bare hands.

6/16/15 at 11:52 AM – Findings were acknowledged with E16 (FSD). The facility failed to ensure that clean and sanitized utensils were handled to prevent contamination of the food- and lip-contact surface.

Backflow Prevention Device, When Required.

A plumbing system shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the food establishment, including on a hose bibb if a hose is attached or on a hose bibb if a hose is not attached and backflow prevention is required by law, by:
(A) Providing an air gap as specified under § 5-202.13; or (B) Installing an approved backflow prevention device as specified under § 5-202.14.

This requirement is not met as evidenced by:

Based on observations and interview, it was determined that the facility failed to ensure

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3201. 6-01.11

that there were effective air gaps at the food prep sink and dishwasher in the kitchen.
Findings include:

6/16/15 at 11:00 AM – An observation of the food prep sink revealed an inadequate air gap.

6/16/15 at 11:55 AM – An observation of the dishwasher revealed the absence of an air gap.

6/16/15 at 12:55 PM – Findings were acknowledged by E1 (NHA). The facility failed to ensure that there were effective air gaps at the food prep sink and dishwasher.

Floors, Walls, and Ceilings.
Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.

This requirement is not met as evidenced by:

Based on observations, it was determined that the facility failed to ensure that the surfaces of two walls in the kitchen were smooth and easily cleanable. Findings include:

6/16/15 at 11:20 AM – An observation of a wall by the dishwasher revealed unsealed wood as the surface and not easily cleanable.

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<p>3201. 6-201.13</p>	<p>6/16/15 at 11:57 AM – An observation of a wall by the stove revealed unsealed wood as the surface and not easily cleanable.</p> <p>6/16/15 at 1:00 PM – Findings were reviewed with E1 (NHA). The facility failed to ensure that the surfaces of two walls in the kitchen were smooth and easily cleanable.</p> <p>Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In food establishments in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch).</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observations, it was determined that the facility failed to ensure that openings between the air conditioning units and walls next to the dishwasher and stove were sealed properly. Findings include:</p> <p>6/16/15 at 11:20 AM – An observation of the wall next to the dishwasher revealed a gap greater than 1 millimeter between the air conditioning unit and the wall.</p> <p>6/16/15 at 11:57 AM – An observation of the wall next to the stove revealed a gap greater than 1 millimeter between the air conditioning unit and the wall.</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	<p>08/22/2015</p>
<p>3201. 6-202.12</p>	<p>6/16/15 at 1:00 PM – Findings were reviewed with E1 (NHA). The facility failed to ensure that openings between the air conditioning units and walls were sealed properly.</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	<p>08/22/2015</p>

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3201. 6- 202.15	<p>Heating, Ventilating, Air Conditioning System Vents.</p> <p>Heating, ventilating, and air conditioning systems shall be designed and installed so that make-up air intake and exhaust vents do not cause contamination of food, food-contact surfaces, equipment, or utensils.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observations, it was determined that the facility failed to prevent the air conditioning unit by the stove from causing contamination of food, food-contact surfaces, equipment, and/or utensils. Findings include:</p> <p>6/16/15 at 11:25 AM – An observation of the air conditioning unit next to the stove revealed cool air blowing towards the food-contact surfaces, equipment, and/or utensils.</p> <p>6/16/15 at 1:00 PM – An observation of the air conditioning unit next to the stove revealed cool air blowing towards food on the steam table.</p> <p>6/16/15 at 1:00 PM – Finding was reviewed with E1 (NHA) in the kitchen. The facility failed to prevent the air conditioning unit by the stove from causing contamination of food, food-contact surfaces, equipment, and/or utensils.</p> <p>Outer Openings, Protected. (A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a food establishment shall be protected against the entry of insects and</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	08/22/2015

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3201.6-301.14	<p>rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observations and interview, it was determined that the facility failed to ensure the openings between the air conditioning units and walls next to the dishwasher and stove were protected against the entry of insects and rodents. Findings include:</p> <p>6/16/15 at 11:20 AM – An observation revealed an opening between the air conditioning unit and the wall next to the dishwasher.</p> <p>6/16/15 at 11:57 AM – An observation revealed an opening between the air conditioning unit and the wall next to the stove.</p> <p>6/16/15 at 1:00 PM – Findings were reviewed with E1 (NHA) in the kitchen. While in the kitchen reviewing findings with E1, she swatted a fly away from her. The facility failed to ensure the openings between the air conditioning units and walls next to the dishwasher and stove were protected against the entry of insects and rodents.</p> <p>Handwashing Signage.</p> <p>A sign or poster that notifies food employees to wash their hands shall be provided at all handwashing sinks used by food employees and shall be clearly visible to food employees.</p> <p>This requirement is not met as evidenced</p>	<p>Please refer to CMS 2567 for F167, F241, F246, F253, F256, F279, F309, F323, F356, F371, F431, F463, F469, F514</p>	08/22/2015

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	<p>by:</p> <p>Based on observation, it was determined that the facility failed to post a visible sign at all handwashing sinks notifying food employees to wash their hands. Findings include:</p> <p>6/16/15 at 10:20 AM – An observation of the handwashing sink in the kitchen revealed the absence of a visible sign notifying food employees to wash their hands.</p> <p>6/16/15 at 12:50 PM – Finding reviewed with E1. (NHA) The facility failed to post a visible sign notifying food employees to wash their hands.</p> <p>16 Del. C. Chapter 11 §1108</p> <p>Posting of inspection summary and other information and public meetings.</p> <p>(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees and visitors the following:</p> <p>(2) A sign prescribed by the Department that specifies complaint procedures and provides the "1-800" hotline number to receive complaints 24 hours a day, 7 days a week. These requirements were not met as evidenced by:</p> <p>Based on observations and interview, it was determined that the facility failed to prominently and conspicuously post for display in a public area of the facility that is</p>	<p>Chapter 11 §1108</p> <p>Corrective Measures for Residents Affected:</p> <p>The facility has placed a "1-800" complaint hotline sign for the State of Delaware's Division of Long Term Care Residents Protection (DLTCRP) in a highly visible place in the facility.</p> <p>Identification of Others with the Potential to be Affected:</p> <p>Facility Residents have the potential to be affected.</p> <p>Measures to Prevent Recurrence:</p> <p>Facility Nurse Educator provided education to facility staff on the need to have the DLTCRP "1-800" complaint posted at all times in a highly visible area where it can be viewed by residents, visitors and staff. (See Exhibit 3)</p>	<p>08/22/2015</p>

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	<p>readily available to residents, employees and visitors the following: a "1-800" complaint hotline sign from the State of Delaware's Division of Long Term Care Residents Protection (DLTCRP). Findings include:</p> <p>From 6/15/15 through 6/19/15, observations throughout the facility revealed the absence of a posted sign from the DLTCRP with the "1-800" complaint hotline number and procedure.</p> <p>In an interview on 6/19/15 at 2:35 PM, E2 (DON) confirmed the finding. The facility failed to ensure that a sign from the DLTCRP specifying a "1-800" hotline number to receive complaints and procedure was displayed in a public area.</p> <p>16 Del. C. Chapter 11, Subchapter VII §1164</p> <p>§ 1164 Nutrition and dietetics staffing.</p> <p>Every residential health facility must at all times provide nutrition and dietetics staffing adequate to meet the care needs of each resident. The staffing level must, at a minimum, include a full-time food service manager. Any food service manager hired after July 1, 2001, must be a registered dietitian or a certified dietitian/nutritionist, a registered dietetic technician, a certified dietary manager, or must have a Bachelor of Science or associate degree in food service management or related field. The educational requirements shall be met</p>	<p>Monitoring of Corrective Action:</p> <p>Facility Administrator will complete random audits to ensure that the DLTCRP "1-800" sign remains posted in a highly visible area in the facility. Audit results will be forwarded to the facility Quality Assurance Committee for a minimum of monthly x 3.</p> <p>Corrective Measures for Residents Affected:</p> <p>Previous Dietary Manager is no longer employed by the facility. The facility has placed an add in the local paper and has begun recruiting efforts to hire a Certified Food Protection Manager. The position will be filled only by someone that is accredited as a Certified Food Protection Manager. Until such time the position has been filled, the kitchen will be supervised by the facility Administrator in combination with the Registered Dietitian.</p>	<p>08/22/2015</p>

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	<p>provided that if an insufficient pool of applicants exists, other qualifications may be deemed acceptable in accordance with regulations promulgated by the Department. A sub-acute transitional care unit of an acute care hospital with 30 beds or fewer is exempt from the provisions of this subsection provided that other licensed personnel perform the duties of this function. Any full-time food service manager with a minimum of 3 years' experience as a full-time food service manager as of July 1, 2001, shall be exempt from the requirements of this subsection.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview, it was determined that the facility failed to have a certified food service manager. Findings include:</p> <p>6/16/15 at 10:00 AM – In an interview, E16 (FSD) stated that his certification as a food service manager expired in 2012.</p> <p>6/16/15 at 12:50 PM – Findings were reviewed with E1 (NHA).</p>	<p>Identification of Others with the Potential to be Affected:</p> <p>Facility Residents have the potential to be affected.</p> <p>Measures to Prevent Recurrence:</p> <p>The facility has Implemented a policy named <i>Dining Service/Certified Food Protection Manager</i> which states that the facility will employ a Certified Food Protection Manager that shows proficiency of required information as evidenced by completing an accredited Certified Food Protection Manager Program and passing a test that is a a part of the accredited program. (See Exhibit 37)</p> <p>Monitoring of Corrective Action:</p> <p>Facility Administrator will conduct Random Audits to ensure that the Certified Food Protection Manager is accredited and maintains their accreditation throughout their employment. Findings will be reported to the facility Quality Assurance Committee for a minimum of monthly x 3.</p>	

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