

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

PRINTED: 09/13/2016
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 07/28/2016
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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 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from July 20, 2016 through July 28, 2016. 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 81. The survey sample totaled thirty two (32).</p> <p>Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; ADLs - Activities of Daily Living, such as bathing and dressing; BUN - Blood Urea Nitrogen (blood test for kidney function); CAA - Care Area Assessment; EMAR - Electronic Medication Administration Record; EMR - Electronic Medical Record; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); mg - milligrams, unit of weight; MOM - Milk of Magnesia; OT- Occupational Therapy; POS - Physicians' Order Sheet, monthly report of active physician's orders; PT - Physical Therapy;</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/26/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 ADL Self-Performance Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; Supervision - oversight, encouragement or cueing; Total Dependence - full staff performance every time activity performed; 3-day Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days; Anxiety - feeling worried, nervous or restless; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; Antianxiety - medication to treat anxiety; Antidepressant - medication to treat depression; AV shunt (arteriovenous fistula) - surgical connection of a vein and artery for dialysis; Bruit/Thrill - assessment of sound and feeling as blood flows in the AV shunt; CAA summary - a dated form indicating where data from the CAA was found; Catheter - a small tube used to drain fluid from the body; Cellulitis - swollen tissues from an infection; Central Venous Access - catheter inserted in neck, chest or groin vein; Cognitively Intact - able to make own decisions; Colace - stool softener; Congestive Heart Failure (CHF) - heart cannot pump enough blood to meet the body's needs causing swelling in feet/legs or fluid in the lungs; Continence - control of bladder and bowel function; Delusions- a belief held with strong conviction despite evidence to the contrary; Dementia- a severe state of cognitive impairment	F 000			

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F 000	Continued From page 2 characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person ' s daily functioning; Dycem - a non-slip material to help stabilize objects; Frequently Incontinent [urine] - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day period; Hemodialysis - procedure to remove waste and fluid from the body; Hypoxia / Hypoxic - not enough oxygen reaching body tissues; Incontinence - loss of control of bladder and/or bowel function; i.e.-that is; Lantus insulin-medication used to control blood sugar; Lasix - medicine to eliminate excessive fluid in the body; Non-pharmacological - any intervention intended to improve health or well-being that does not involve the use of any drug or medicine; Occasionally Incontinent [urine] - less than 7 episodes of incontinence during a 7 day period; Paranoia- involves intense anxious or fearful feelings and thoughts often related to persecution, threat or conspiracy. Occurs in many mental health disorders; Prompted void - technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule; Psychosis - loss of contact/touch with reality; Psychotropic - medication used to treat psychosis; Senna Plus - laxative; Severe Cognitive Impairment - unable to make	F 000			

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F 000	Continued From page 3 own decisions; Subcutaneous Injection - an injection given in the fatty tissue just under the skin; Urinary Tract Infection (UTI) - bacteria in the urine	F 000			
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to purchase a surety bond to assure the security of residents' personal funds deposited with the facility. Findings include: During an interview with E5 (Business Manager) on 7/27/16 at 12:25 PM E5 stated that the facility did not have a surety bond to provide security for resident funds. The facility was managing personal funds for 68 randomly reviewed, of the 81 residents. E5 confirmed the previous owners had \$60,000 coverage which expired when the new owners took over June, 2015. E5 stated she spoke with E1 (NHA) who said E8 (one of the owners) was "working on it". These findings were reviewed with E1 [NHA] and E2 (DON) on 7/28/16 at 1:50 PM.	F 161	Corrective measures for residents affected: There was no negative outcome to residents affected. The facility obtained a Surety bond on July 28, 2016 in the amount of \$60,000.00. (Exhibit 2) Identification of others with the potential to be affected: Facility residents with a RFMS account have the potential to be affected. Measures to prevent Recurrence: Facility administrator received one on one education related to the need to keep an active surety bond at all times. Monitoring of Corrective Measures: Facility administrator or designee will complete random audits to ensure that the facility has an active Surety bond. The	9/23/16	

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F 161	Continued From page 4	F 161	audits will occur on the following schedule : Daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until 100 % compliance is noted for three consecutive months. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 3)		
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on interviews, it was determined that the facility failed to make prompt efforts to resolve a resident's concern for 1 (R61) out of 32 sampled residents. Findings include:</p> <p>During the Stage 1 Resident Interview on 7/20/16 at 2:30 PM, R61 stated his roommate snores at night and keeps him awake all night. "He was moved to my room because his old roommate complained about him. When I wake him and ask him to roll over so he stops snoring, my roommate cusses at me. He said 'shut up n----'. Another time he yelled at me 'n---- kiss my ass f-- - you' and walked out of the room." R61 said he knows he cannot have a private room, but he told E7 (SW) about this problem 2 weeks ago and has</p>	F 166	<p>Corrective measures for resident affected :</p> <p>Facility social worker offered R61 a room change. R61 declined a room change at this time. Since the time of the survey exit, R61's roommate was asked if he would like to change rooms and he agreed. This room change occurred on 08/04/2016.</p> <p>Identification of others with the potential to be affected: Facility residents have the potential to be affected. Facility Department heads completed interviews with facility residents or their responsible party, to determine if the</p>	9/23/16	

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F 166	<p>Continued From page 5</p> <p>not heard anything back and nothing has changed. R61 said E7 was supposed to talk to his roommate, but that his roommate repeats himself and does not remember things.</p> <p>During an interview on 7/25/16 at 2:12 PM, E7 stated: We looked into this concern of R61 and it is unfounded. This roommate moved into R61's room on 6/1/16; prior to that R61 had not had a roommate for several months. R61 would prefer a private room. E7 did confirm that she was aware that R61 complained that his roommate cusses and calls him racial slurs. E7 said she told R61 that: "some people are just different." E7 said that R61's new roommate did not get along with his previous roommate and had to be moved, and it was not a good situation. E7 said we have talked to his roommate about this, but he has dementia. E7 said she has tried to encourage a better relationship between R61 and his roommate. E7 said it is not true that I have not followed up with R61; we check on him weekly to make sure everything is ok. I asked E7 if she had any documentation about R61's concern, her discussions with him or her plan to address his concern. E7 said no.</p> <p>During an interview on 7/27/16 at 12:00 PM, E7 confirmed that she did not offer R61 to move to another room when he made this complaint.</p> <p>During a phone interview on 07/28/16 at 6:24 AM, E13 (night shift nurse supervisor) said she was not aware that R61 had complained that his roommate snores or has cursed at him, and she has not observed it either.</p> <p>During a phone interview on 07/28/16 at 6:30 AM, E24 (R61's usual night shift nurse) said she has</p>	F 166	<p>residents have any outstanding, unresolved concerns, and that the resident concerns are written on the appropriate resident grievance form with supporting documentation to show measures taken by the facility to resolve the grievance. (Exhibit 4)</p> <p>Measures to Prevent Recurrence: DON provided facility social worker with one on one education regarding the importance of documenting resident grievances on the grievance form, investigation of concerns and follow up, appropriate interventions for resident concerns, communicating concerns to the floor staff and documenting actions and outcomes on the grievance form. (Exhibit 5)</p> <p>The facility has updated the care plan meeting format to include a time period during the meeting where residents or their responsible party are questioned to determine if there were any grievances in the review period to ensure that the grievance was documented, investigated and concluded appropriately if applicable.</p> <p>Monitoring of Corrective Measures: Facility administrator or designee will complete random interviews with facility residents to ensure that the resident does not have an outstanding grievance, that a grievance form was initiated, that the grievance was investigated appropriately, that appropriate interventions were offered to satisfy the grievance and that facility staff are aware of the concern if</p>		

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F 166	<p>Continued From page 6</p> <p>observed R61's roommate snoring and at times he gets up and walks out of his room at night, but she has never observed him cursing at R61. R61 has not complained to E24 about his roommate snoring or cursing at him.</p> <p>During a phone interview on 07/28/16 at 6:45 AM, E25 (R61's usual night shift CNA) said that R61 has told her he would like his roommate to move out of his room because of his snoring. E25 has never observed the roommate cursing at R61.</p> <p>During an interview on 7/28/16 at 9:00 AM, E6 (UM) stated he was not previously aware of R61's concern.</p> <p>During an interview with E2 (DON) and E9 (ADON) on 7/28/16 at 10:25 AM, they were not able to provide any additional information related to R61's concern.</p> <p>During an interview on 7/28/16 at 11:45 AM, R61 stated E7 spoke with him this morning and suggested he turn his TV volume up when his roommate is snoring, but other than that, staff have not offered to change his room or any other options to resolve his concern.</p> <p>The findings were discussed with E1 (NHA) and E2 at the exit conference on 7/28/16 at 1:50 PM.</p>	F 166	<p>appropriate to assist with monitoring of the grievance. The audit sample size will be 10% of the population, and the selected sample will change with each audit. The audit will occur on the following schedule: Daily until such time that 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then weekly until 100% compliance is noted for three consecutive weeks, then monthly until such time that 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility Quality Assurance Committee.</p>		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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</p>	F 246		9/23/16	

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F 246	<p>Continued From page 7 endangered.</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 provide reasonable accommodation of individual needs for safety in four rooms (204, 209, 311 and 315) out of 25 rooms reviewed with regard to the call bells being within reach in the event of a fall. Findings include:</p> <p>During Stage 1 (7/20/16 9:00 AM - 4:00 PM and 7/21/16 8:00 AM - 4:00 PM), and on 7/22/16 at 10:20 AM the bathrooms in the following rooms had call bell strings that were too short for a resident to reach from the floor:</p> <p>204, 209, 311 and 315</p> <p>During an interview on 7/27/16 at 10:00 AM E23 (Environmental Director) confirmed these findings.</p> <p>These findings were reviewed with E1 (NHA) and E2 [DON] on 7/28/16 at 1:50 PM.</p>	F 246	<p>F246 Corrective Measures for residents Affected: There was no negative outcome to residents affected. The call bells located in the bathrooms of rooms 204,209,311 and 315 have been lengthened to ensure that they can be reached from the floor.</p> <p>Identification of Others with the Potential to be Affected: Facility Environmental Service Director completed a facility wide audit of resident rooms and bathrooms to ensure that the call bells were of adequate length to be accessed from the floor in the event of a resident fall. (Exhibit 6)</p> <p>Measures to Prevent Recurrence: Facility Staff members received education on the importance of monitoring the physical environment in regards to safety. This education included the need for call bells to be long enough to be reached from the floor in the event of a resident fall and the need to report to maintenance when a call bell does not meet this standard. (Exhibit 1)</p> <p>Monitoring of call bell length has been added to the facility preventative maintenance program. Maintenance techs</p>		

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F 246	Continued From page 8	F 246	will review and sign off on call bell length of one unit per week. This will remain on the maintenance program as preventative maintenance. (Exhibit 8) Monitoring of Corrective Action: Environmental Service Director or Designee will complete random audits of resident rooms/bathrooms to ensure that the call bell length is long enough to be accessed in the event that the resident had a fall to the floor. The audit sample size will be 10% of facility rooms/ bathrooms and the sample census will change with each audit. The audit will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels that are in substantial compliance. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 6)		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/ NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		9/23/16	

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F 248	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, interviews, record review and review of other facility documents, it was determined that the facility failed to consistently implement an individualized program of activities, consistent with the identified needs of the comprehensive assessment, to meet the needs of one (R50) out of 32 sampled residents. Findings include:</p> <p>Clinical record review for R50 completed on 7/27/2016 included the following:</p> <p>Annual Minimum Data Set (MDS) completed on 9/22/2015 documented that R50 rarely/never makes self understood and rarely/never understands others. Under Section F of the MDS staff documented the following areas that triggered and were part of the care plan decision making process:</p> <p>-Psychosocial wellbeing - Resident prefers listening to music and doing things with groups of people.</p> <p>-Activities - Resident enjoys self-propelling around the facility.</p> <p>4/7/2016 Activities progress notes documented that R50 continues to enjoy strolling around the facility socializing with staff. She will stroll into and out of the live entertainment & socials. She enjoys people watching & receiving visits from her family.</p> <p>Quarterly Minimum Data Set (MDS) dated 6/2/2016 documented R50 as severely cognitively impaired.</p>	F 248	<p>Corrective Measures for resident Affected:</p> <p>There was no negative outcome to resident R50.</p> <p>R50's activity care plan has been updated to reflect measurable resident specific goals based off of the comprehensive assessment and resident specific interventions to meet the resident's physical, mental and psych-social needs. R50's Activity care plan reflects 1:1 room visits 2-3 times per week. Activity interventions include, sensory stimulation (hand rubs) during reminiscing, cognitive and reminiscing activities using doll therapy as resident has shown interest in nurturing and pleasure from doll therapy, and encouraging involvement in religious programs as resident enjoys hymn singing . Resident will be assessed on a quarterly basis and with significant change in condition to ensure that the activity interventions meet the resident's physical and social needs.</p> <p>Identification of others with the Potential to be Affected:</p> <p>Facility residents have the potential to be affected.</p> <p>Facility Activity Director completed a 100% audit of facility residents to ensure that the plan of care meets the resident's interests and the physical, mental and psycho-social wellbeing of each resident as evidenced by measurable resident specific goals and interventions that are</p>		

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F 248	<p>Continued From page 10</p> <p>6/6/2016 Activities progress notes - R50 continues to self-propel around the facility people watching, communicating with staff and peers that are familiar to her. She strolls in and out of special events, religious programs.</p> <p>Activity Assessment Form dated 6/6/2016 - documented R50's activity pursuit pattern - current interest as country and spiritual music as well as special events. The resident's preferred setting is to participate inside the facility/off unit. The document indicated that the resident loves ice cream and will attend social events depending on how R50 feels.</p> <p>During an interview with the surveyor on 7/20/2016 at 1:40 PM, R50's family member indicated that staff at the facility do not take R50 to activities routinely. The family member does come to the facility regularly and would like to see R50 attend more activities.</p> <p>Surveyor observations on 7/22/2016 from approximately 11:11 AM to 12:06 PM and again from 1:56 PM to 3:02 PM showed that R50's family member came and fed the resident lunch. The resident did not attend any activities during those times. R50 was often seen self-propelling down the hallway by R50's room or sitting in a wheelchair by the front entrance area, unengaged</p> <p>Observations on 7/25/2016 at 9:14 AM until approximately 11:53 AM revealed that R50 was in bed at one point dressed, the television (TV) was on but the programming had no music or singing. The resident received AM care. R50 was not</p>	F 248	<p>based off of the comprehensive assessment. (Exhibit 9)</p> <p>Measures to Prevent Recurrence: Activity Director received one on one education from the facility Director of Nursing on the care plan process to include assessment, goal formulation, interventions and reassessment for effectiveness. This education included the need to have the residents care plan be resident specific with measurable goals and interventions that implement an individualized program based off of the comprehensive assessment that meet the needs and interests of the resident. (Exhibit 10)</p> <p>Monitoring of Corrective Measures: Facility Administrator or designee will complete random audits of the activity plan of care to ensure that the activity program is resident specific based on the information obtained in the comprehensive assessment, contains measurable goals and has resident specific interventions to meet the residents interests and the physical, mental and psycho-social wellbeing of each resident. The audit sample size will be 10% of the facility population and the audited population will change with each audit. The audit will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for</p>		

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F 248	<p>Continued From page 11</p> <p>observed engaged in activities during these times</p> <p>During an interview on 7/26/2016 at 9:51 AM with the surveyor, E4 (Activities Director) stated the activity staff use participation logs to keep track of attendance. E4 said that residents who are bedbound have one to one visits and that there is an assessment of what each resident liked to do prior to coming to the facility. Self-directed residents that are not bedbound and refuse to come to activities may prefer "self-directed" activities so the staff keep track of those residents as well.</p> <p>Surveyor observations on 7/26/2016 at 9:58 AM revealed R50 in the hallway near room self-propelling in wheelchair. R50 does not respond to questions but vocalizes at times. At 10:45 AM R50 was still self-propelling in wheelchair around the unit, unengaged.</p> <p>A review on 7/26/16 was conducted of R50's participation logs for June and July 2016 as well as the daily participation log for all residents who attended activities for the same period of time.</p> <p>The June 2016 logs showed that R50 did not attend any scheduled facility activities for the entire month. There were family visits checked off 6 days out of 30. Unstructured activities that were marked off for R50 were strolls and TV. The resident was seen self-propelling around the facility and had the TV on in her room most of the month. Morning greetings were checked off for the entire month.</p> <p>The July 2016 participation log did reflect that the resident attended facility activities on the 13th and</p>	F 248	three consecutive months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 9)		

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F 248	<p>Continued From page 12</p> <p>14th of the month. R50 attended 5 different sessions on each of those days. There was one family visit checked off on July 5, 2016. Again the staff marked off strolls and TV as activities for most of the month. A review of the daily participation logs also showed that the resident attended one activity in the evening on 7/9/2016 and another evening activity on 7/18/2016 that were not marked on R50's individual sheet. Under the participation codes there were no refusals to attend an activity recorded for either month. The comments made by staff on both logs are "strolls around the facility." The resident attended scheduled activities 4 days out of 31 days.</p> <p>Surveyor observation on 7/27/2016 revealed the resident in bed at approximately 9:10 AM, still in bed at 9:27 AM to 10:05 AM, unengaged, the television was on but there was no music or singing (resident's preference). At 10:47 AM the surveyor noted R50 was still in bed but dressed, the Daily Chronicle was on top of the TV which was turned on to a program that had no singing or music.</p> <p>On 7/27/2016 at 10:08 AM, the surveyor interviewed E4 again and was informed that morning greetings included dropping off the Daily Chronicle which is delivered to all resident rooms and has some trivia, menu and activities for the day with any changes from the monthly activities calendar or main menu. This is done around 8:30 AM to 9:30 AM each morning and for residents who have trouble reading staff will read the information to them.</p> <p>During an interview with the surveyor on 7/27/2016 at 11:53 AM E11 (Activities Aide) stated that</p>	F 248			

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F 248	Continued From page 13 some staff help bring residents to activities and if E11 makes a request staff will bring residents but once the activity starts, E11 can't leave to get more residents to attend the activity. On 7/28/2016 the surveyor also reviewed R50's May 2016 participation log and the daily participation logs which showed family visits and that R50 attended one activity on three separate days out of 31 days. Morning greetings were checked off for the month. The document showed that strolls and TV are marked off for the month. No refusals to attend an activity are recorded.	F 248			
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 determined that the facility failed to maintain bathrooms and bedrooms in 8 out of 25 rooms (104, 205, 207, 208, 209, 306, 311, and 315) reviewed in an orderly, sanitary and comfortable interior. Findings include: Observations made during Stage 1(7/20/16 9:00 AM - 4:00 PM and 7/21/16 8:00 AM - 4:00 PM), 7/	F 253	Corrective Measures for Residents Affected: The peeling paint in rooms 206 and 306, and in the bathrooms of rooms 205 and 208 has been repaired. The bathroom door in room 209 now closes easily. The sink faucet handle in the bathroom of room 315 has been repaired.	9/23/16	

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F 253	<p>Continued From page 14 22/16 2:00 PM - 3:00 PM and 7/26 10:00 AM -10:20 AM:</p> <ul style="list-style-type: none"> -paint peeling in rooms 205 and 306, and bathrooms of rooms 205/207 and 208 -bathroom door of room 209 does not open or shut easily -rusty cold water handle on sink faucet in the bathroom of room 315 -bathroom vents in need of repair in rooms 104 and 315 -loose bed side rails in room 311 <p>During an interview on 7/27/16 at 10:00 AM E23 (Environmental Director) confirmed these findings.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p>	F 253	<p>The bathroom vents in room 104 and 315 have been repaired. The loose bedrail in room 311 has been tightened.</p> <p>Identification of others with the potential to be affected: Facility residents have the potential to be affected. Facility Environmental Service Director completed an audit of the physical plant to ensure that the environment is sanitary, orderly and comfortable. The audit focused on identifying areas with chipped paint, ensuring smooth easy door closures, that faucets are free from rust, that exhaust vents are functioning and that call bells are secure. (Exhibit 39)</p> <p>Corrective Measures to Prevent Recurrence: The facility will utilize a preventative maintenance program through Tels. Areas of paint, door closures, Plumbing fixtures (to include faucets), bathroom vents and bedrails have been placed in the program. They will be reviewed monthly by the environmental team to ensure that there are no issues in the identified areas. (Exhibit 12) Facility Department Heads have been assigned rooms to be reviewed on a weekly basis. The audit will include evaluation of the environment to ensure that the environment is sanitary, orderly and comfortable. Audits will be completed and given to the facility administrator. Areas identified will be provided to maintenance for correction.</p>		

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F 253	Continued From page 15	F 253	<p>Facility Environmental Service Director received one on one education related to the importance of maintaining an environment that is sanitary, orderly and comfortable. This education included how to develop and implement a preventative maintenance program that identifies and corrects environmental areas that require correction. Areas addressed were paint, ensuring no rust on plumbing fixtures, door closures, bathroom vents and side rails. (Exhibit 11)</p> <p>Facility Staff members received education in the importance of reporting any identified maintenance issues to the maintenance department using the Tels program. (Exhibit 1)</p> <p>Monitoring of Corrective Action: Facility Administrator or designee will complete random audits of the physical plant to ensure that the environment is free from peeling paint, doors close easily, bathroom vents are functioning appropriately, side rails are secure, and sink faucets are free from rust. The audit census will include 10% of the resident rooms/bathrooms per audit and will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels substantial compliance has been achieved. (Exhibit 39)</p>		

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F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272		9/23/16	

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F 272	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview it was determined that for three (R85, R86 and R52) out of 32 sampled residents the facility failed to ensure the accuracy of the comprehensive assessment. Findings include:</p> <p>1. The following was reviewed in R85's clinical record:</p> <p>5/10/16 - Nurse's notes and facility incident report documented R85 sustained a fall that occurred when the spouse was attempting to assist the resident out of bed. The resident sustained a superficial abrasion to the right knee.</p> <p>6/4/16 - Quarterly MDS documented that one fall with injury and one fall with major injury occurred during the assessment period.</p> <p>An interview on 7/26/16 at 11:56 AM with E2 (DON) revealed that she did not believe R85 had any falls with major injury during the 6/4/16 MDS review. E2 later confirmed this with the RNAC [E3] that there was only one fall with no major injury and this was an error on the MDS.</p> <p>2. The following was revealed in R86's clinical record:</p> <p>7/06/16 - R86's Annual MDS assessment lacked 19/20 dates and 8/20 locations in the space provided for information related to the CAA to be documented.</p> <p>During an interview on 7/27/2016 at 1:45 PM with E3 it was confirmed that the dates were missing</p>	F 272	<p>Corrective Measures for Residents Affected-</p> <p>There was no negative outcome to residents affected</p> <p>A MDS revision was completed on resident R85 to accurately reflect that resident only had one fall during the review period without major injury.</p> <p>A MDS revision was completed on resident R86 to complete the CAA summary and accurately reflect the residents ADL status.</p> <p>A MDS revision was completed for resident R52 to accurately reflect resident <input type="checkbox"/>s true level of incontinence.</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 a facility wide audit of MDS <input type="checkbox"/> to ensure that resident falls are accurately coded on the MDS along with an accurate reflection of the ADL and continence status based on review of assessment and other supporting documentation.(Exhibit 38)</p> <p>Measures to Prevent Recurrence:</p> <p>Facility MDS Coordinator received one on one education related to the need to ensure accurate completion of the MDS. This education included the need to thoroughly review ADL documentation and to complete an assessment when documenting the ADL status of a resident</p>	
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F 272	<p>Continued From page 18</p> <p>on the CAA summary for all but one of 20 listed care areas and location information for 8/20 areas.</p> <p>The facility failed to accurately document a comprehensive assessment as evidenced by missing documentation on the CAA summary form.</p> <p>3. Cross Refer F315, Example 1 Review of R52's clinical record revealed:</p> <p>2/3/16 - Admission MDS Assessment documented R52 was occasionally incontinent of urine.</p> <p>2/8/16 - 2/10/16 - A 3-day voiding diary documented two episodes when the resident voided on the toilet, once the resident was wet and once R52 was dry prior to the toileting.</p> <p>During an interview with E1 (NHA) and E2 (DON) on 7/28/16 at 3:30 PM to review the CNA documentation from the seven day look-back period for the Admission MDS assessment, the only documentation available was from the night shift on 1/31/16 when the resident was identified as being incontinent. E2 informed the surveyor about a problem with electronic documentation not recording data which was corrected on 2/5/16. The CAA from that MDS assessment indicated staff interview (no specific staff listed) was used for the determination of the bladder incontinence section. E2 presented a written statement from E6 [LPN, UM] about a 7/28/16 conversation with R52's daughter. The daughter said the resident was "totally in a diaper all the time" before being admitted to the facility. E2 informed the surveyor that the resident's daughter who provided the</p>	F 272	<p>to ensure accurate information on the MDS. The MDS coordinator also received education on reviewing documentation of falls, injury associated with the falls and amount of falls prior to completing the assessment to ensure accuracy of fall information on the MDS along with reviewing the definitions of falls and falls with major injury as defined in the RAI manual. The process of reviewing continence information was also reviewed with the MDS Coordinator. This education included how to collect the data, interpret the data and how to document the data on the MDS. (Exhibit 35)</p> <p>The facility MDS Coordinator will bring information to the facility morning meeting to review any changes in ADL status or continence on the MDS. This information will be reviewed with the interdisciplinary team. The IDT will review the supporting documentation for the change in ADL status to ensure the most accurate coding is used to describe the residents ADL status, and that appropriate assessments have been completed to identify the cause of the change and to ensure that all resident appropriate interventions are in place to ensure that the resident remains at the highest practicable level of functioning. (Exhibit 35)</p> <p>Monitoring of Corrective Action: DON or designee will complete random audits to ensure that the MDS is accurately coded to reflect the resident's current ADL status, continence level and that falls are accurately captured on the MDS. The audit sample size will consist of</p>		

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F 272	Continued From page 19 statement was R52's caregiver prior to admission and that incontinence was the main reason for admission to the facility and should have been coded as frequently incontinent on the admission MDS assessment. Review of incontinence data from the seven days immediately following the correction of the computer capturing issue (2/5/16 - 2/12/16) discovered, of the 23 shifts, that R52 was incontinent 20 shifts, continent 1 shift, had no void 1 shift and missing documentation 1 shift. Based on this information, the resident was frequently incontinent and not occasionally incontinent as coded in the MDS.	F 272	10% of MDS <input type="checkbox"/> completed and will occur on the following schedule. Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 38)		
F 278 SS=D	These findings were reviewed with E1 and E2 on 7/28/16 at 1:50 PM. 483.20(g) - (j) ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		9/23/16	

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F 278	<p>Continued From page 20</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on interview and record review it was determined that the facility failed to accurately assess for one (R86) out of 32 sampled residents in the area of locomotion off of the unit. Findings include:</p> <p>The following was revealed in R86's clinical record:</p> <p>4/1/16 - 4/7/16 - Review of CNA flow sheets for R 86 documented, in the area of locomotion off the unit, that R86 was totally dependent during the seven-day look back period of observation for MDS assessment.</p> <p>4/7/16 - A quarterly MDS Assessment documented R86 as requiring extensive assistance, defined as the resident involved in the activity with staff providing weight-bearing support in the area of Locomotion off the unit.</p> <p>During an interview on 7/27/2016 at 1:45 PM with E3 (RNAC), it was confirmed that the CNA documentation identified R86 as dependent for locomotion off of the unit.</p>	F 278	<p>F278</p> <p>Corrective Measures for Residents Affected:</p> <p>There was no negative outcome to residents affected.</p> <p>A correction was submitted for R86's MDS to accurately reflect his locomotion off the unit.</p> <p>Identification of others with the potential to be affected:</p> <p>Facility residents have the potential to be affected.</p> <p>An independent audit was completed by a RNAC of the most recently completed MDS to ensure accurate coding was completed related to locomotion, ADL's, falls and continence based on the documentation provided for the lookback period. (Exhibit 38)</p> <p>Measures to Prevent Recurrence:</p> <p>The facility MDS coordinator received one on one education from the DON on how to accurately complete and code the MDS</p>	
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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 278	Continued From page 21 The facility failed to accurately document the MDS evidenced by inaccurately coding R86's assessment in the area of locomotion off the unit. These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.	F 278	based on the RAI manual instructions and information obtained in the look back period for the MDS. This included data collection, assessment and coding on the MDS.(Exhibit 35) 10% of the weekly MDS <input type="checkbox"/> scheduled for submission will be reviewed by an independent RNAC in the areas of ADL <input type="checkbox"/> s, continence and locomotion to ensure accurate coding prior to submission. Monitoring of Corrective Action: Independent RNAC will complete audits of facility MDS <input type="checkbox"/> s to ensure accurate coding was completed related to locomotion, ADL <input type="checkbox"/> s, falls and continence based on the documentation provided for the lookback period. The sample size will be 10% of MDS <input type="checkbox"/> completed and will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels that are in substantial compliance. (Exhibit 38)		
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	F 279		9/23/16	

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F 279	<p>Continued From page 22</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>The facility failed to develop an individualized plan of care with measurable objectives and specific interventions to meet the assessed needs of two (R99, R50) out of 32 sampled residents. Findings include:</p> <p>1a. Cross refer F329</p> <p>The following was reviewed in R99's clinical record:</p> <p>Review of the admission plan of care documented R99 was admitted on 4/29/16 on psychoactive medications which included an antipsychotic for psychosis/mood disorder, a mood stabilizing medication, an antidepressant, a sleep medication and an antianxiety medication.</p> <p>5/2/16 - History and physical documented psychosis with major depressive disorder,</p>	F 279	<p>F279 Corrective Measures for Residents Affected:</p> <p>There was no negative outcome to residents affected.</p> <p>Resident R99's Behavior care plan has been updated to reflect specific targeted behaviors and individualized interventions for the targeted behaviors. Interventions include: redirect resident by taking stroll in wheelchair, redirect resident by talking about resident interests including family, music and sports, re-approach resident at a later time when refusal of care occurs and sit to stand exercises to decrease anxiety.</p> <p>Resident R99's fall care plan has been</p>		

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F 279	<p>Continued From page 23</p> <p>significant behavioral issues with psychosis with dementia and anxiety with psychotic features.</p> <p>5/5/16 initiated and active on 7/27/16 during review - The Behavior Management Program in the care plan for "Resident requires ongoing redirection, monitoring and structured activities to alter behavior problem of repetitive questions or statements, insomnia, sadness, crying, hitting at staff during care, paranoia. Resident refusing to wear admission arm band". The care plan failed to identify how the resident presented with paranoia, delusions and psychosis and what approaches to use for behaviors associated with these diagnoses.</p> <p>5/31/16 - A Psychiatry Consultation note documented dementia with delusions, psychosis, anxiety, insomnia and major depressive disorder.</p> <p>7/20/16 - Behavior monitoring was initiated in the treatment record to monitor for agitation as evidenced by resistance to care pushing and grabbing during care.</p> <p>During an interview on 7/27/16 at 2:00 PM with E 2 (DON) the lack of specific care plan approaches based on the comprehensive assessment was discussed and confirmed as lacking.</p> <p>b. Cross refer F323 example #3.</p> <p>The following was reviewed in R99's clinical record and facility documents:</p> <p>4/29/16 - Accident Report - R99 slid from wheel chair to floor in dining room. No injuries.</p>	F 279	<p>updated to reflect individualized, resident specific interventions for fall prevention. Interventions include: bed and chair alarm, low bed, dycem to wheelchair, non-skid footwear, lap buddy, sit to stand exercises every evening and therapy referrals as needed.</p> <p>Resident R50's activity care plan has been updated to reflect measurable, resident specific goals and interventions. R50's Activity care plan reflects 1:1 room visits 2-3 times per week. Activity interventions include, sensory stimulation (hand rubs) during reminiscing, cognitive and reminiscing activities using doll therapy as resident has shown interest in nurturing and pleasure from doll therapy, and encouraging involvement in religious programs as resident enjoys hymn singing . Resident will be assessed on a quarterly basis and with significant change in condition to ensure that the activity interventions meet the resident's physical and social needs.</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 a 100 % audit of facility residents with behaviors to ensure that the behavior care plan is resident specific identifying target behaviors and resident specific interventions. (exhibit 14)</p>		

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F 279	<p>Continued From page 24</p> <p>5/1/16 - Care Plan for Falls: Potential for falls related to unsteady gait, poor positioning, medications, behaviors, cognitive status. Interventions included: anticipate resident needs with regard to ADL's, rehab referral for evaluation secondary to potential for falls, ensure use of proper footwear and bed and chair alarm. This care plan did not include that R99 is legally blind or that he has a history of falls prior to admission.</p> <p>5/2/16 - History and physical documented R99 was admitted on 4/29/16 from another facility with a history of falls, psychosis with major depressive disorder, significant behavioral issues with psychosis with dementia and anxiety with psychotic features.</p> <p>7/8/16 - Accident Report - R99 slid to floor on knees from wheelchair. No injuries.</p> <p>7/10/16 - "Dycem to wheelchair" ordered, but was not added to Fall Care Plan until 7/25/16.</p> <p>7/17/16 - Accident Report - R99 had 2 falls from wheelchair. No injuries.</p> <p>7/25/16 - Care Plan for Falls: Interventions ordered on admission 4/29/16 where added (bed in lowest position when not providing care and non-skid footwear except during ADL's). Intervention ordered on 5/3/16 was added (transfer with one assist, may use sit to stand for evenings if he gets tired and is unsafe to transfer with assist of one). "Dycem to wheelchair" ordered on 7/10/16 added. The facility identified the need to care plan for falls on admission, but failed to include all assessed approaches until 7/25/16.</p>	F 279	<p>Facility Nurse Managers completed a 100 % audit of facility residents at risk for falls to ensure that ordered safety devices and resident specific interventions are clearly identified on the fall care plan. (Exhibit 15)</p> <p>Facility Activities Director completed a 100 % audit of activity care plans to ensure that the resident goals and interventions are residents specific and measurable. (Exhibit 9)</p> <p>Measures to Prevent Recurrence: Licensed nurses received education on the care planning process. This included the need for assessment, resident specific goal implementation and how to implement resident specific interventions that address the root cause of the issue along with reevaluating interventions if they are ineffective. This education also included the need to update the care plan upon admission, with change in condition and at minimum on a quarterly basis. (Exhibit 1)</p> <p>The Activity Director received one on one education regarding the care planning process. This education included assessment, formulating a goal, specific interventions and monitoring and evaluating the goals and interventions. (exhibit 10)</p> <p>The facility has initiated a monthly meeting to address residents with antipsychotic medications to monitor behaviors, medications and the plan of care. This meeting will review the resident</p>		

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F 279	<p>Continued From page 25</p> <p>During an interview on 7/27/16 at 11:00 AM, E8 (Memory Care Nurse Manager) stated that "Dycem to wheelchair" has been on the Nursing TAR since she ordered it on 7/10/16, but it was not added to the care plan until 7/25/16.</p> <p>2. Cross reference to F248 Review of R50's clinical record revealed:</p> <p>Annual Minimum Data Set (MDS) completed on 9/22/2015 documented that R50 rarely/never makes self understood and rarely/never understands others. Under Section F of the MDS staff documented the following areas that triggered and were part of the care plan decision making process:</p> <p>-Psychosocial wellbeing - Resident prefers listening to music and doing things with groups of people. -Activities - Resident enjoys self-propelling around the facility.</p> <p>R50's activities care plan effective date 10/8/2015 under the problem section showed the following:</p> <p>"Altered/limited ability to participate/passive observer in relation to participation/involvement in activities secondary to cognition/resident choice/physical limitation."</p> <p>Goals are: "maintain present level of socialization and leisure interests through participation in the various programs. Such as; strolls into musical entertainment, religious services & throughout the facility." Maintain present level of cognitive functioning and socialization through participation. Resident will continue to self-propel around the facility socializing with staff and peers, she will</p>	F 279	<p><input type="checkbox"/>s plan of care to ensure that is an accurate up to date reflection of the resident's specific behaviors and interventions implemented to address the targeted behaviors.</p> <p>The facility has revised the incident report investigation checklist to be used as Quality Assurance tool to assist the nursing staff in ensuring that the incident and interventions are placed on the plan of care in a timely fashion. This tool will be used by the Quality Assurance Director to ensure that the appropriate resident specific care plan updates are in place. (Exhibit 16)</p> <p>Monitoring of Corrective Action: DON or designee will complete random audits of resident behavior care plans to ensure that the plan of care accurately reflects resident specific behaviors and interventions. The audit sample size will be 10% of residents with behaviors and will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels that are in substantial compliance. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 14)</p> <p>DON or designee will complete random</p>	
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F 279	<p>Continued From page 26</p> <p>stroll into live entertainment and religious services, leaving at the resident's leisure within the next 90 days. Effective date of goals is 10/08/2015 with a future review date of 8/3/2016.</p> <p>There are no measurable objectives to meet the resident's activity needs. The goals are not individualized to adequately address the resident's cognitive status, provide the needed support to get to the various activities routinely, and how the staff would promote participation in R50's preferred activities in an effort to engage the resident.</p> <p>Interventions are the following: -to provide a monthly calendar -provide escorts as needed -provide stimulation using the radio or television -promote participation in spiritual or religious activities -maintain preferred independent leisure activity -communicate with interdisciplinary team any changes in mood and behavior</p> <p>The interventions are not specific on how activity staff will promote participation in spiritual or religious activities and when escorts would be provided for the resident to attend activities.</p> <p>Quarterly Minimum Data Set (MDS) dated 6/2/2016 documented R50 as severely cognitively impaired. R50 can self-propel around the unit, the resident requires staff assistance to escort the resident to specific activities on and off the unit based on both assessments related to R50's cognitive status.</p> <p>The findings were discussed with E1 (NHA) and E2 at the exit conference on July 28, 2016 at 1:50</p>	F 279	<p>audits of facility residents at risk for falls, fall care plan to ensure that is accurately reflects current fall interventions. The audit sample size will be 10% of identified residents and will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels that are in substantial compliance. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 15)</p> <p>LNHA or designee will complete random audits of facility residents activities care plan to ensure that the goals and interventions are resident specific and measurable. The audit Sample size will be 10% of the facilities population and will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months until such time that the facility feels that are in substantial compliance. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 9)</p>		

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F 279	Continued From page 27 PM.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation it was determined that the facility failed to revise the care plan for one (R9) out of 32 sampled residents when the method to perform hemodialysis changed. Findings include: Review of R9's clinical record revealed: 9/30/15 nursing note - [Name/type of dialysis catheter] left chest capped and clamped with	F 280	9/23/16	
			F280 Corrective Measures for Resident Affected: There was no negative outcome to resident affected. Resident R9's dialysis care plan was updated on 07/25/2016 to include the dialysis catheter as the access point for dialysis and the care and emergency care	

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F 280	<p>Continued From page 28 dressing to site intact.</p> <p>12/15/15 - Care plan problem for dialysis (last updated 7/11/16) included the intervention to assess AV shunt for bruit and thrill. The care plan was not revised to include the non-functional AV shunt or the addition of the dialysis catheter from September, 2015.</p> <p>During an interview with E12 (RN) on 7/25/16 at 9 :30 AM the nurse identified that routine catheter care (i.e., flushing, dressing change) was provided by the dialysis center and indicated the need to apply pressure if the catheter became damaged or was pulled out in the facility.</p> <p>7/25/16 (9:43 AM) Observation - E15 [RN UM] called the dialysis center and requested instructions for the emergency care for dislodgement or breakage of the dialysis catheter. E15 stated the dialysis center should send information with the resident following completion of today's treatment.</p> <p>During an interview with E15 on 7/25/16 at 9:50 AM E15 confirmed the dialysis catheter was not included in R9's care plan and stated "I'm going through care plans now and will be changing that "</p> <p>During an interview with E15 on 7/26/16 at 4:20 PM E15 stated she spoke with E16 (Physician) who ordered pressure to be applied to the catheter and to send the resident to the emergency room for catheter dislodgement or bleeding.</p> <p>During an interview on 7/27/16 at 10:45 AM, E15 stated that R9 had an AV shunt in the upper arm</p>	F 280	<p>interventions for the dialysis catheter.</p> <p>Identification of Others with the Potential to be Affected: Facility Residents on dialysis have the potential to be affected.</p> <p>Facility Nurse Managers completed a 100 % audit of facility residents receiving dialysis to ensure that the access point and care of the dialysis access site is accurately reflected in the plan of care. This included ensuring that emergency care for the site is accurately reflected. (Exhibit 17)</p> <p>Measures to Prevent Recurrence: Licensed nurses received education on the care planning process. This included the need for assessment, resident specific goal implementation and how to implement resident specific interventions that address the root cause of the issue along with reevaluating interventions if they are ineffective. This education also included the need to update the care plan upon admission, with change in condition and at minimum on a quarterly basis. Education was provided that the care plan for dialysis residents must be resident specific to include access site and care for the access site to include routine and emergency care. (Exhibit 1)</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of facility residents receiving dialysis to ensure that the dialysis site is accurate and routine and emergency care</p>		

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F 280	Continued From page 29 which became non functional and that the resident "had the catheter a long time." 7/28/16 (11:50 AM) - E15 provided the papers from the dialysis center which included the following information: if any issues with the catheter call dialysis center 5:00 AM - 4:30 PM or send to [name of local hospital] emergency department. 7/28/16 - Review of R9's dialysis care plan found that, on 7/25/16, the intervention to check the dialysis catheter every shift was added and the intervention to check AV shunt every shift was removed.	F 280	for the site is clearly listed on the plan of care. The audit will occur on the following schedule: Daily until such time that 100% compliance is achieved for 5 consecutive days, then three times a week until such time that 100% compliance is achieved for three consecutive weeks, then weekly until such time that 100% compliance is achieved for three consecutive weeks, then monthly for three months or until such time that the facility feels that are in substantial compliance. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 17)		
F 281 SS=E	These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a clinical record review, staff interviews and a review of other facility documents, it was determined that the facility failed to rotate injection sites and/or document the sites used according to acceptable clinical standards of nursing and facility practice for one (R6) out of 32 sampled residents. Findings include: Review of R6's clinical record review revealed: R6 received Lantus insulin 23 units	F 281	F281 Corrective Measures for Resident Affected: There was no negative outcome to resident affected. The transcription of the physicians order for R6's insulin has been revised in the emar to make injection site documentation a mandatory task.	9/23/16	

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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 07/28/2016
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 281	<p>Continued From page 30</p> <p>subcutaneously (SQ) daily at bedtime according to physician's orders and the electronic Medication Administration Record (eMAR) for June 2016. The June eMAR reflected that the administering nurses did not rotate the injection sites and/or record the sites used for 19 times out of 30 times the insulin was administered to R6.</p> <p>R6 received Lantus insulin SQ at bedtime according to physician's orders and the July eMAR. There was no evidence that administering nurses did rotate injection sites and/or record the sites for 17 times out of 24 times the insulin was administered to R6.</p> <p>During an interview with the surveyor on 7/27/2016 at 9:23 AM E8 (UM) of the Memory Care Unit, who was the medication nurse on duty, stated that the nurses are to rotate the insulin injection sites and are to record the sites used on the eMAR.</p> <p>On 7/27/2016 at approximately 9:30 AM E2 (DON) was asked by the surveyor, if the facility had a policy on insulin administration and E2 stated no, that nursing staff follow the standard set forth in the Lippincott Manual of Nursing Practice, seventh edition and referred the surveyor to page 723 which included the following:</p> <p>"For subcutaneous injections administered repeatedly, such as insulin, rotate sites. Choose one injection site in one area, move to a corresponding injection site in the next area and so on. When returning to an area, choose a new site in the area Document the procedure."</p> <p>During a separate interview on 7/27/2016 at 9:57 AM E2 acknowledged that E2 did not know why</p>	F 281	<p>Identification of Others with the Potential to be affected: Facility residents receiving insulin have the potential to be affected. Nurse Managers completed an audit of facility residents receiving insulin to ensure that site documentation is a mandatory requirement to document in the emar. (Exhibit 18)</p> <p>Measures to prevent Recurrence: Licensed nurses received education on the importance of site rotation when administering insulin. Education included how to access previous site information, the procedure as outlined in the Lippincott manual and the correct method of transcribing the order in the emar to have site documentation auto populate as a required field for documentation on the MAR. (Exhibit 1)</p> <p>Nurse Managers will be pulling new order reports to view transcription of the new orders to ensure that insulin orders have been transcribed correctly to have site documentation as a required field.</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of insulin site documentation to ensure that the injection site is documented on the MAR and to ensure that the site was rotated. The audit will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100%</p>		

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F 281	Continued From page 31 the rotation sites were not entered on the eMAR by the administering nurses. E2 further stated that the administering nurses have access on the eMAR system to a 3-day look back period to check rotation sites. The June and July 2016 eMARs for R6 showed that injection sites were not rotated and/or recorded for 3 to 4 days consecutively on at least 7 separate occasions. The findings were discussed with E1 (NHA) and E2 at the exit conference on July 28, 2016 at 1:50 PM.	F 281	compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 19)	
F 309 SS=E	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 record review and interview it was determined that for one (R85) out of 32 sampled residents the facility failed to ensure the physician's plan of care for vital sign monitoring was implemented as ordered. Findings include: Review of R85's clinical record revealed the following: R85 had a current July 2016 physician's order originating on 9/9/15 for blood pressure (BP) and pulse (P) to be monitored weekly on Fridays.	F 309	F309 Corrective Measures for Resident Affected: There was no negative outcome to R85. The order in the emar for R85's blood pressure monitoring has been updated to have the documentation of the blood pressure as a required field. Identification of others with the potential to be Affected: Facility residents with routine blood	9/23/16

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F 309	<p>Continued From page 32</p> <p>May 2016 - No evidence that the BP and P were assessed and documented. June 2016 - Only one documented BP and P on 6 /13/16. July 2016 - BP and P as of 7/26/16 were documented 7/18, 7/19, 7/20, 7/21, 7/22, 7/24 and 7/25/16. There was no evidence that the BP and P was done the first 3 Fridays of July [7/1, 7/ 8, 7/15/16].</p> <p>During an interview on 7/27/16 at 9:39 AM with E 6 (UM, LPN) revealed that the above BP and P readings were all that could be found for R85. E6 further revealed that the EMR was set up in a manner that allowed nursing staff to initial completion of the vital sign task without actually documenting the finding. He stated that since the omitted vital signs were discovered, the EMR had been fixed to require the actual vital signs reading be entered in the computer.</p> <p>During an interview on 7/26/2016 at 2:58 PM E2 (DON) confirmed that there was no evidence the above vital signs for BP and P were obtained as ordered by the physician.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 7/28/16 at 1:50 PM.</p>	F 309	<p>pressure monitoring orders have the potential to be affected. Nurse Managers completed an audit of facility residents with standing vital sign orders to ensure that they have been transcribed in the emar to have documentation of the vital sign reading as a required field. (Exhibit 20)</p> <p>Measures to Prevent Recurrence: Licensed Nurses received education on the importance of documenting the vital sign information in the medical record. This education included how to transcribe the order in the medical record to have the BP information trigger as a required field for documentation. (Exhibit 1)</p> <p>Nurse Managers will be pulling new order reports to view transcription of the new orders to ensure that the transcription of the vital sign monitoring orders have been transcribed correctly to have blood pressure documentation as a required field.</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of facility residents with routine blood pressure monitoring orders to ensure that the order has been transcribed correctly to have the blood pressure value as a required task, and to ensure the blood pressure monitoring has occurred as ordered. The sample census of the audit will be 10% of the population with standing blood pressure orders and will occur on the following schedule: Daily until 100% compliance is noted on 5</p>		

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F 309	Continued From page 33	F 309	consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 21)		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review, interview and review of other facility documentation it was determined that the facility failed to provide the necessary assessment and services to restore as much normal bladder function as possible for two (R52 and R95) out of 32 sampled residents. Findings include:</p> <p>Review of facility documents revealed: Undated facility policy (last revised 6/3/16)</p>	F 315	<p>F315 Corrective Measures for Residents affected:</p> <p>R52 did not have a decline in continence. The initial MDS had a coding error. Resident remained incontinent through both assessment dates. A MDS correction was completed and submitted for the admission MDS to reflect this information. A three day voiding diary was completed</p>	9/23/16	

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F 315	<p>Continued From page 34</p> <p>entitled Bladder Assessment included the following procedures:</p> <ul style="list-style-type: none"> - All residents, upon entering the facility will receive a bladder assessment in [name of documentation software]. - A bladder assessment review will be performed if incontinence/toileting issues are identified to determine if the resident would benefit from a toileting program. - A 3-day voiding diary may be completed to identify patterns of incontinent episodes - Establish the appropriate toileting plan which will best meet the resident's needs in promoting continence. - The toileting plan chosen is then placed in the physician's orders, the CNA form and care plan in [name of documentation software]. - The nursing assistants are responsible for following the designated toileting schedule and documenting on the toileting plan form ordered in [name of documentation software]. - Evaluate the resident's progress on a monthly basis to determine if the resident's incontinence is improving. - Maintain or change the toileting plan as necessary based on results of the evaluation. <p>Cross Refer F272, Example 3</p> <p>1. Review of R52's clinical record revealed:</p> <p>1/27/16 - R52 admitted to facility.</p> <p>1/28/16 - Bladder section of the admission nursing assessment documented R52 had no problems voiding and had no urinary catheter. The following questions in the assessment were not answered: Bladder habits - continent / incontinent Dribbles - yes / no</p>	F 315	<p>08/24/2016-08/26/2016 and analyzed. The resident remains at her baseline of incontinent and unaware of urge to void. Resident has a current care plan in place to address her incontinence.</p> <p>R95-A comprehensive assessment has been completed. A three day voiding diary was completed 08/23/2016-08/25/2016 and was analyzed. Resident was continent of urine with no episodes of incontinence and his care plan reflects this.</p> <p>Identification of others with the potential to be affected: Facility residents with a decline in continence have the potential to be affected.</p> <p>Facility Nurse Managers completed an audit of the MDS assessment to identify any facility resident that has had a decline in continence from the previous assessment period. The audit ensured that a bladder assessment has been completed, and that the plan of care reflects interventions based off of the comprehensive assessment to restore as much bladder function as possible. (Exhibit 22)</p> <p>Measures to Prevent Recurrence: Licensed Nurses have received education on the importance of providing appropriate treatment and services to restore or maintain as much bladder function as possible. This education</p>		

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F 315	<p>Continued From page 35</p> <p>Urine color - (free text response) Urine consistency - (free text response) Time of last voiding - (free text response)</p> <p>2/3/16 - Admission MDS Assessment documented R52 had severe cognitive impairment, needed limited assistance with toileting and was occasionally incontinent of urine</p> <p>2/5/16 (last reviewed 5/5/16) - Care plan problem for urinary incontinence included the following interventions: 3-day voiding diary; medications as ordered; encourage fluid intake; observe for changes in behavior; and prompted voiding every 1-2 hrs with positive reinforcement (the toileting plan selected for the resident).</p> <p>2/8/16 - 2/10/16 - A 3-day voiding diary documented two episodes when the resident voided on the toilet, once the resident was wet and once R52 was dry prior to the toileting. This diary also recorded that the resident denied awareness of the urge to void throughout the three days. R52 did, however, remain dry for 5-8 consecutive hours over the nighttime hours.</p> <p>Review of nursing progress notes found no evidence of an analysis of the 3-day voiding diary.</p> <p>4/15/16 Physical Therapy Discharge Summary - R52 received physical therapy starting 1/27/16 and improved from maximum assistance for transferring to / from bed or chair to needing minimal / moderate assistance using a front wheeled walker.</p> <p>3/19/16 - Physician order included an antibiotic for 10 days to treat a UTI which was discovered</p>	F 315	<p>included how to interpret information from the comprehensive assessment, including voiding diary, how to complete the bladder assessment and how to initiate resident specific goals and interventions based on the comprehensive assessment. The education also included the need to complete a comprehensive assessment when a change in condition is noted, to reassess the goals and interventions to maintain the highest practical level of functioning for the resident. (Exhibit 1)</p> <p>The facility MDS Coordinator received one on one education on the importance of accurate coding. This education used guidance from the RAI manual on coding incontinence. (Exhibit 35)</p> <p>The facility has implemented a new bladder assessment. The assessment will use a score system to better identify residents with incontinence and their needs. The bladder assessment will trigger nursing staff to initiate a three day voiding diary if necessary. The MDS Coordinator will also hold an IDT meeting when a change in bladder status occurs to review the comprehensive assessment, initiate additional assessments as needed and to review interventions implemented to restore as much bladder function as possible.</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of residents that have triggered for a decline in continence to ensure that the</p>		

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F 315	<p>Continued From page 36</p> <p>during an ER evaluation after passing out while on the toilet.</p> <p>4/26/16 - Quarterly MDS Assessment showed the resident needed extensive assistance for toileting and was now frequently incontinent of urine (a decline of R52's continence).</p> <p>During an interview with E2 (DON) on 7/26/16 at 10:25 AM E2 stated there was not a separate bladder assessment in the computer and voiding diary analysis should be in a nursing note.</p> <p>There was no evidence in the electronic or paper record that a 3-day voiding diary and/or bladder assessment was completed after the decline in continence was identified.</p> <p>During an interview with E6 [LPN UM] on 7/26/16 at 11:00 AM, E6 confirmed an assessment, including a 3-day voiding diary, was not performed.</p> <p>During an interview with E19 (CNA) on 7/27/16 at 10:40 AM E19 said R52 would go to the toilet when admitted, but had become more incontinent since then. When asked if R52 was on a toileting plan, E19 stated "I don't know, but I can find out for you."</p> <p>7/23/16 - 7/27/16 - Observation found no bedside commode in the resident's room.</p> <p>During an interview with E6 on 7/27/16 at 1:40 PM E6 explained that R52 used a bedside commode initially and prompted voiding was defined as asking the resident to determine if there was a need to urinate. When asked what interventions were attempted after a decline in</p>	F 315	<p>MDS was coded accurately, that if a true decline occurred that a comprehensive assessment was completed at the time of discovery of the decline and that the care plan reflects resident specific interventions to restore as much bladder function as possible. The audits will occur on the following schedule: Daily until 100 % compliance is noted for three consecutive evaluations, then three times a week until such time 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100 % compliance is noted on three consecutive evaluations, then monthly until 100% compliance is noted on three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 22)</p>		

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F 315	<p>Continued From page 37</p> <p>April, E6 said "I don't think we did anything. They used to toilet her when she got up in the morning and again when she laid down in the afternoon."</p> <p>During an interview with E1 (NHA) and E2 on 7/28/16 at 3:30 PM E2 presented a written statement from E6 about a 7/28/16 conversation with R52's daughter. The daughter said the resident was "totally in a diaper all the time" before being admitted to the facility. E2 informed the surveyor that the resident's daughter providing the statement was R52's caregiver prior to admission and that incontinence was the main reason for admission to the facility and should have been coded as frequently incontinent on the admission MDS assessment.</p> <p>Review of incontinence data from the seven days immediately following the correction of the computer capturing issue (2/5/16 - 2/12/16) discovered, of the 23 shifts, that R52 was incontinent 20 shifts, continent 1 shift, had no void 1 shift and missing documentation 1 shift. Based on this information, the resident was frequently incontinent on admission and not occasionally incontinent as coded in the MDS.</p> <p>2. Review of R95's clinical record revealed:</p> <p>6/2/16 - Admission MDS Assessment documented the resident was cognitively intact and was always continent with no episodes of urinary incontinence.</p> <p>6/13/16 - 6/18/16 - Hospitalized for arm cellulitis/ swelling and treatment with antibiotics.</p> <p>6/19/16 Physician Orders - Lasix 40 mg to be given daily for swelling. This medication causes</p>	F 315			

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F 315	Continued From page 38 increased urination. 6/24/16 - 90-Day MDS Assessment / Significant change in status assessment documented the resident was still cognitively intact but was now occasionally incontinent. 6/27/16 - Care plan problem for urinary incontinence was created and included the following interventions: medications as ordered; encourage fluid intake; monitor for signs of UTI; use slide board to transfer in/out of bed; use prompted voiding every 1-2 hours with positive reinforcement (the toileting plan selected for the resident). During an interview with E2 on 7/26/16 at 10:25 AM E2 stated there was not a separate bladder assessment in the computer and voiding diary analysis should be in a nursing note. There was no evidence of a bladder assessment and/or voiding diary within the electronic and paper record. During an interview with E6 on 7/26/16 at 11:00 AM E6 confirmed no voiding dairy was in the chart and said "It was not done." These findings were reviewed with E1 and E2 on 7/28/16 at 1:50 PM.	F 315			
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	F 323		9/23/16	

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F 323	<p>Continued From page 39 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, record review and interview it was determined that for four (R84, R 85, R86 and R99) out 32 sampled residents the facility failed to either provide assistive devices to prevent falls and/or evaluate and analyze data pertaining to resident falls. Finding include:</p> <p>1. The following was reviewed in R85's clinical record:</p> <p>8/1/15 - Fall assessment score of 20 (above 10 is high risk).</p> <p>9/22/15 - Treatment orders for bed in lowest position when not providing care with mats to floor beside bed (originated 2/24/15) and keep fall mat between bed and wall to help protect resident skin.</p> <p>10/8/15 - Care plan for potential for falls related to history of falls, decrease vision, impaired cognition, and impaired mobility with approaches for; bed alarm in bed, dycem to wheelchair, ensure call bell in reach, fall mats beside bed (originated 2/24/15), bed in low position, keep fall mat between bed and wall, med review for recurrent falls, rehab referral for evaluation secondary to potential for falls.</p> <p>7/26/16 - Review of a facility incident report from 9/20/15 documented that resident rolled out of bed onto floor bed alarm was functioning.</p>	F 323	<p>F323</p> <p>Corrective action for resident affected: R85- Staff member providing care for R85 received formal education at the time of the incident related to the importance of ensuring that safety devices are in place prior to leaving the room. R86- Clarification was obtained related to the fall investigation and it was determined that current fall interventions are appropriate. Residents fall care plan accurately reflects current resident specific interventions. R99 currently has his dycem in place. R99 <input type="checkbox"/>s fall care plan is up to date indicating the resident specific fall interventions. The interventions are also being signed off on the TAR. In regards to the incident with the fire extinguisher that occurred on 07/17/2016, the facility investigated the incident and placed the issue in QA. On 07/19/2016, a plastic fire extinguisher cabinet was ordered to prevent the resident from being able to access the fire extinguisher. On 07/21/2016, the fire extinguisher cabinet arrived at the facility and was installed on the unit. R84- Resident has Dycem in place as ordered. Resident <input type="checkbox"/>s fall care plan is up to date with appropriate resident specific interventions for fall prevention.</p>		

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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 07/28/2016
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F 323	<p>Continued From page 40</p> <p>Resident stated "I just rolled out of the bed". Skin tear to right outer elbow. Review of the investigation revealed that the fall mat was not on the floor beside the bed when the resident fell. Staff statements revealed staff started to provide care and left the room without putting mat back in place. The resident fell out of bed about 7 minutes later without the mat on the floor.</p> <p>An interview on 7/28/16 at 9:58 AM with E2 (DON) reviewed the fall and investigation, confirming that R85's fall mat was not in place at the time of the 9/20/15 fall from bed.</p> <p>It is unclear how the facility utilized information from incident reports to prevent future falls for R 85.</p> <p>2. The facility implemented a policy on Falls dated 6/3/16, that directs staff to evaluate each resident to determine the risk of falls and to identify intervention to minimize or prevent falls from occurring.</p> <p>Review of the clinical record for R86 revealed an admission to the facility on 8/10/15 with diagnosis that included dementia.</p> <p>Review of the care plan potential for falls related to unsteady gait, poor positioning, medications, behaviors, cognitive status initiated on 12/17/15 and last updated 7/12/16, included the following interventions; anticipate residents needs with regards to ADL'S, bed/chair alarms, ensure that the call bell is within easy reach at all times, ensure proper use of footwear, provide education on safety techniques, provide reality orientation and a rehabilitation referral for evaluation</p>	F 323	<p>Identification of others with the potential to be affected:</p> <p>Residents at risk for falls with ordered safety devices have the potential to be affected.</p> <p>Nurse Managers completed an audit of residents at risk for falls to ensure that ordered safety devices are on the resident, care planned and have an associated physician order. (Exhibit 15) DON completed an audit of facility incident reports for resident falls that have occurred in the previous thirty days to ensure that the investigation is complete, that ordered interventions are appropriate based on the investigation and that the care plan is updated with the interventions . (Exhibit 23)</p> <p>Measures to Prevent Recurrence: Nursing Department employees have received education on the investigative process. This includes education on how to complete root cause analysis, how to complete a thorough investigation and how to use the information obtained from the root cause analysis to formulate a resident specific intervention. This education included the need to clearly identify interventions that were in place at the time of the incident, information that should be obtained in the statement/ interview process and how to analyze this data. (Exhibit 1)</p> <p>Nursing Department employees received</p>		

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F 323	<p>Continued From page 41 secondary to potential for falls.</p> <p>4/7/16 - a quarterly MDS assessment coded R86 as needing extensive assistance with locomotion off the unit, locomotion on the unit and transfers.</p> <p>6/3/16 - A physician order was written for a Dycem to R86's wheelchair.</p> <p>7/6/16 - An annual MDS assesment revealed that R86 was coded as dependent for locomotion off the unit, how the resident moves to and returns from off unit locations and required extensive two person assistance for locomotion on the unit and for transfers.</p> <p>An interview with facility staff on 7/20/16 at 11:33 AM revealed that R86 had two falls, 6/2/16 and 7/11/16, both without injury, within the last thirty days.</p> <p>7/25/16 - During a random observation at 1:04 PM R86 was observed with a Dycem overlay on top of the wheelchair cushion.</p> <p>7/26/16 - Review of the 6/1/16 Incident report revealed that at 6:50 PM an unwitnessed fall occurred in the resident's room and R86 "was found laying on right side in floor and stated trying to get reacher". The employee statement read, "I went to answer the call bell in the room ...when I knocked and entered I found the resident on floor ". Corrective actions documented on the incident report related to the 6/1/16 fall included, education was completed with resident in regards to using the call bell when needs assistance, and Dycem will be placed in the wheelchair. Incident report documentation was unclear as to whom activated the call bell that alerted the</p>	F 323	<p>education on the importance of ensuring ordered safety devices are in place as ordered. This education informed the staff on where to obtain ordered safety device information, how to obtain supplies and signing the TAR for the ordered device. (Exhibit 1)</p> <p>An incident report check off sheet has been updated to assist the nursing staff in gathering the information needed for a thorough investigation. This form will trigger the nurse to identify interventions in place at the time of the incident, to interview all staff, to obtain physicians order for the intervention and to ensure the care plan is updated with current interventions. (Exhibit 16)</p> <p>Monitoring of Corrective Action: DON or designee will complete random audits of facility incident reports to ensure that the investigation is complete and thorough, that all statements have been obtained, that care plan has been updated with current interventions and the investigation initiates safety devices present during the incident. The audit sample size will be 10% of facility incidents and will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100 % compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to</p>		

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F 323	<p>Continued From page 42</p> <p>witness, or whether the wheelchair cushion contributed to the R86's fall. It was unclear whether R86 slid out of the chair.</p> <p>7/26/16 - Review of the 7/9/16 incident report revealed that, at 2:20 PM, R86 "slid to the floor on his buttocks after trying to stand up from his wheelchair unassisted. The employee witness statement read "R86 was in the front lobby, he was leaning forward and fell on the floor." A conflicting witness statement read, "I saw that resident fell down, sitting on buttocks, no head hit ". Corrective actions documented on the incident report related to the 7/9/16 fall included, resident has fall prevention measures in place, resident is currently on therapy, will continue to monitor. It was unclear if R86 slid or fell prior to the fall, and whether the Dycem implemented as a result of the 6/1/16 fall was appropriate as a fall prevention intervention and if it was actually in place at the time of the fall.</p> <p>During an interview on 7/25/16 at 12:11 PM, E21 (CNA) reported that she had never observed R86 "self propelling in the hallways".</p> <p>During an interview on 7/25/16 on 12:39 PM with E15 (unit manager), E15 revealed that following the conclusion of the facility investigation into R86 's fall on 6/1/16, that she did not discover who pressed the call bell at the time of the fall, whether it was R86 or his roommate at the time. E15 confirmed that at the conclusion of the facility investigation did not reveal what R86 was attempting to use his reacher to retrieve at the time of his fall on 6/1/16. When asked how R86 arrived to the lobby area just prior to his fall on 7/9/16, E15 stated " the assumption was he maneuvered himself in the wheelchair because</p>	F 323	<p>the facility Quality Assurance Committee. (Exhibit 23)</p> <p>DON or designee will complete random audits of ordered safety devices to ensure that they are in place as ordered. The audit will consist of a random 10% of the facility population and will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 15)</p>		

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F 323	<p>Continued From page 43 no one had taken him up there".</p> <p>During an interview on 7/25/16 at 1:15 PM with E 22 (Physical Therapy Director), it was confirmed that PT did not receive a referral from nursing following R86's 6/1/16 fall until 6/15/16.</p> <p>During an interview on 7/26/16 at 9:49 AM with E 15, it was confirmed that the intent of the Dycem placement for R86 was to be on top of the wheelchair cushion, to prevent R86 from sliding out of the wheelchair. When E15 was asked whether the cushion was still in the wheelchair after R86's two falls, E15 responded " I don't remember what I asked concerning how he was sitting in the chair.</p> <p>During an interview on 7/26/16 10:36 AM with E9 (ADON), it was asked who rang the call bell notifying staff that R86 fell on 6/1/16, which was not made clear in the incident report generated on 6/2/16. E9 reported that clarification as to who rang the call bell was made on 7/25/16 stating " we have since found out it was R86's roommate who is no longer at the facility. E9 was asked if R 86's wheelchair cushion was a factor in his fall on 6/1/16, and whether the resident slid out of the chair or leaned forward, E9 explained, "I review all the incidents but I don't actually do all of the investigation. I have since found out [during follow up interviews on 7/25/16] that the cushion stayed in the chair and did not fall to the floor. During the same interview, E9 was asked what was the intention of adding a Dycem and what was the intended placement of the Dycem when it was documented as a corrective action, E9 stated "I don't know, It would be a guess on my part." E9 was asked why there was a two-week time span between R86's fall 6/1/16 and the PT referral on 6</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>/15/16, E9 explained that facility expectation is as soon as possible.</p> <p>During an interview on 7/26/16 at 10:45 AM with E2 (DON), E2 was unable to clarify why R86 was not immediately referred to PT following his fall on 6/1/16. E2 stated that the facility goal was to refer a resident who has fallen to PT in 24-48 hours, however that policy was not implemented until 6/3/16. R86 had a care plan intervention for rehabilitation referral for evaluation secondary to potential for falls since 12/17/15.</p> <p>During an interview on 7/26/16 at 10:49 AM E9 was unable to state, whether R86 was capable of self propelling to the lobby or was totally dependent for transfer and stated " I would have to look back at the timeframe". During the same interview, E9 was unable to provide clarity between two witness summary statements, one statement indicated that that R86 slid to the floor, the other witness statement indicated R86 was leaning forward and fell. E9 was unable to disclose which witness statement was accurate and stated "at this point I would have to re-interview."</p> <p>During an interview on 7/26/16 at 11:36 AM with E9 it was reported that confirmation of R86's transfer to the lobby just prior to his fall on 7/7/9/16 was not clarified until a follow up interview was conducted on 7/25/16.</p> <p>R86 had two falls within thirty days, 6/1/16 and 7/9/16 and at the conclusion of the facility investigation as evidenced by review of closed incident reports, there was insufficient documentation to determine the hazards and risk associated with the falls and whether subsequent</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>corrective actions and interventions were appropriate and/or effective.</p> <p>The facility failed to analyze the data collected in the incident reports and whether subsequent corrective actions and interventions were appropriate and/or effective.</p> <p>3. The following was reviewed in R99's Clinical record:</p> <p>A new order for "Dycem to wheelchair" was written on 7/10/16 after R99 was found on the floor on his knees in front of his wheelchair on 7/8 /2016.</p> <p>An Accident Report dated 7/17/2016 at 3:30 PM documented that the nurse heard an alarm going off and ran to investigate. The nurse found R99 sitting on the floor with the alarm going off on the chair. R99 was assessed and neurological checks implemented. R99 had no apparent injuries. A new order for therapy evaluation was written, but R99 was already receiving physical therapy. R99 was discharged from OT on 6/16/16 and referred to restorative nursing. Notifications were made to the physician and responsible party . There was no indication from the report or the nursing progress notes from 7/17/2016 (7:39 PM to 8:16 PM) whether R99 had the dycem in place or not at the time of the fall.</p> <p>The same nursing progress notes documented that R99 at approximately 4:00 PM was wandering down the hall in the wheelchair and staff heard a bumping sound and observed the resident had knocked a fire extinguisher off the wall. Residents on the unit had to be assisted out</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>of the area to the lobby because the fire smoke alarm went off. A code red had been called. The fire department came and secured the environment. There was no accident/incident report generated regarding how the resident was able to knock the fire extinguisher off the wall or an evaluation of the incident to prevent reoccurrence.</p> <p>A Fall Risk Evaluation was completed on 7/17/2016. R99 was determined to be at high risk for falls- total score of 16.</p> <p>The 7/17/2016 accident report also showed that R99 fell again at 6:30 PM, 2 and 1/2 hours, after the fire extinguisher incident. R99 was in the hallway trying to touch the floor then the alarm went off and the resident slid or fell to the floor before staff could respond. There is no indication whether or not the dycem was in place at the time of this fall.</p> <p>7/25/16 at 2:40 PM - Observation of R99 in his wheelchair on the nursing unit with no dycem in place on the wheelchair. Chair alarm was in place on the wheelchair. This observation was confirmed with E8 (Memory Care Nurse Manager) at this time. E8 went to therapy department with R99 and asked them to put a dycem on R99 ' s wheelchair.</p> <p>7/25/16 - Care Plan for Falls: Interventions ordered on admission 4/29/16 where added (bed in lowest position when not providing care and non-skid footwear except during ADL's). Intervention ordered on 5/3/16 was added (transfer with one assist, may use sit to stand for evenings if he gets tired and is unsafe to transfer with assist of one). "Dycem to wheelchair"</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>ordered on 7/10/16. These approaches were not added to the care plan until 7/25/16.</p> <p>During an interview on 7/27/16 at 11:00 AM, E8 [Memory Care Manager] stated that "Dycem to wheelchair" has been on the Nursing TAR since she ordered it on 7/10/16, but it was not added to the care plan until 7/25/16 and not added to the CNA flow sheet until 7/17/16 and that no CNA signed it until 7/25/16.</p> <p>While the facility completed incident reports for R 99's falls it is unclear if the facility evaluated the use of an assistive device and the effectiveness of their interventions.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p> <p>4. Clinical record review for R84 on 7/26/2016 revealed the following:</p> <p>Annual Minimum Data Set (MDS) dated 5/6/2016 stated that the resident was cognitively intact.</p> <p>Review of incident reports for R84 for a six month period of time revealed that on 6/7/2016 on the evening shift the resident was found on the floor by nursing. R84 sustained skin tears to the right upper arm and buttocks areas with some bruising to other areas of the body. R84 was attempting to pick something up off the floor and slid out of the wheelchair. The report indicated that the resident has alarms but refuses to use them.</p> <p>Physician orders reflected that there was an order written on 6/8/2016 for dycem to wheelchair.</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>Clarification of the order was written on 7/26/2016 which read dycem between wheelchair seat and cushion every day 7am to 7pm and 7pm to 7am.</p> <p>Surveyor observation on 7/25/2016 at 3:35 PM for R84 was in the wheelchair with no dycem in place</p> <p>Surveyor observation 7/26/2016 at 12:03 AM - R 84 in the room in the wheelchair, the TV on, resident leaning forward in wheelchair fixing her bed which was already made. Safety devices were in place including the dycem as ordered and in accordance with the care plan.</p> <p>7/26/2016 1:24 PM - Care Plan reviewed- problem area identified for falls related to unsteady gait, hx of falls at home, wears glasses, uses of water, and noncompliance with bed and chair alarm clip, removing dycem from cushion and transferring without assistance (added 7/26/2016).</p> <ul style="list-style-type: none"> -Risk versus benefits have been educated with resident and responsible party who verbalize understanding. -Resident will be free of injury related to falls -Resident will verbalize understanding of risk versus benefits of transferring unassisted -Alarms as ordered -Dycem between wheelchair seat and cushion -Ensure use of proper footwear -Provide education on safety techniques -Therapy referral as needed -Use appropriate assistive device and level assistance as recommended by rehab <p>During an interview with the surveyor on 7/28/</p>	F 323			

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F 323	Continued From page 49 2016 at 12:12 PM E2 stated that the care plan did have the dycem listed as a safety device prior to 7/26/2016 but was updated with specifics about where to place it and stated the resident sometimes removes it. It is unclear how the facility evaluated the effectiveness of the interventions in place and how they evaluated the need to modify the interventions.	F 323			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/23/16	

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F 329	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R99) out of 32 sampled residents the facility failed to ensure adequate monitoring of psychoactive medications and failed to ensure behavioral interventions were attempted before pharmacological interventions. Findings include: The facility's Policy and Procedure for Behavioral Monitoring (undated) documented: Residents with behavioral monitoring ordered will be documented by the licensed nurse under the NUR[Nursing]-Behavioral/Intervention. Documentation will contain the individual behavior to be monitored and will contain side effect monitoring specific for any medication ordered for Behavior management. Review of the initial plan of care documented R99 was admitted on 4/29/16 on psychoactive medications which included an antipsychotic for psychosis/mood disorder, a mood stabilizing medication, an antidepressant, a sleep medication and an anxiety medication. The following was reviewed in R99's clinical record: a. 4/29/16 - 7/20/16 - The record lacked evidence of behavior monitoring for the behaviors associated with the psychosis, mood disorder and anxiety that required pharmacological intervention. 5/5/16 - The Behavior Management Program in the care plan for "Resident requires ongoing redirection, monitoring and structured activities to	F 329	F329 Corrective Measures for Resident Affected: There was no negative outcome to resident affected. R99's behavior care plan has been updated to reflect resident specific behaviors that require the use of psychotropic medications to include: insomnia, sadness, repetitive questions, crying, hitting at staff during care, verbally accosting staff and others and throwing chairs. R99 has a behavior monitoring flow sheet in place to monitor for these specific behaviors. Identification of Others with the Potential to be Affected: Facility residents on antipsychotic medications have the potential to be affected. Nurse Managers completed an audit of facility residents receiving psychotropic medications to ensure that the plan of care addresses resident specific, targeted behaviors that warrant the use of the psychotropic medication. (Exhibit 24) Nurse Managers completed an audit of facility residents receiving psychotropic medications to ensure that resident specific behaviors are being monitored daily. (Exhibit 24)		

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F 329	<p>Continued From page 51</p> <p>alter behavior problem of repetitive questions or statements, insomnia, sadness, crying, hitting at staff during care, paranoia. Resident refusing to wear admission arm band". There was no evidence that these behaviors were being monitored.</p> <p>5/2/16 - History and physical documented psychosis with major depressive disorder, significant behavioral issues with psychosis with dementia and anxiety with psychotic features.</p> <p>5/31/16 - A Psychiatry Consultation note documented dementia with delusions, psychosis, anxiety, insomnia and major depressive disorder.</p> <p>7/20/16 - Behavior monitoring was initiated in the treatment record to monitor for agitation as evidenced by resistance to care, pushing and grabbing during care. There was no behavior monitoring initiated that would be associated with the use of R99's diagnoses and use of psychoactive medications.</p> <p>b. 4/29/16 - Physician's order for an antianxiety medication twice a day as needed for agitation.</p> <p>June 2016 - MAR documented the medication was administered 7 times. All 7 opportunities lacked evidence of non-pharmological interventions and effectiveness of the medication. 5 out of 7 administrations lacked a reason for the use of the PRN medication.</p> <p>July 2016 - MAR documented the medication was administered 11 times. 10 out of 11 opportunities lacked evidence of non-pharmological interventions and effectiveness. 8 out of 11 administrations lacked a reason for the use of the</p>	F 329	<p>Nurse Managers completed an audit of facility residents receiving psychotropic medications to ensure that effectiveness documentation after PRN administration is a mandatory task in the EMAR. (Exhibit 26)</p> <p>Measures to Prevent Recurrence: Licensed nurses received education on the importance of implementing non-pharmacologic interventions prior to giving a resident a psychotropic medications. This education included the need to document the failed interventions in the resident chart. The education also included the need for the plan of care to be resident specific with specific targeted behaviors and the need to monitor the specific behaviors on a daily basis. (Exhibit 1)</p> <p>The facility has implemented a new behavior monitoring tool that will allow staff members to track resident specific behaviors every shift. Licensed nurses have received education on this tool. (Exhibit 25)</p> <p>Monitoring of Corrective Action: DON or designee will complete random audits to ensure that residents on a psychotropic medication have a plan of care in place that accurately identifies specific behaviors that indicate the use of a psychoactive medication. This audit will also ensure that resident specific behaviors are being monitored q shift. Audit will include a random 10% of the facility population on a psychotropic</p>		

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F 329	Continued From page 52 PRN medication. An interview on 7/27/16 around 2:00 PM with E2 (DON) confirmed that the behavior monitoring for agitation was not started until 7/20/16. It was further determined that the description of resisting care did not describe the extreme behaviors that R99 actually exhibits. An interview on 7/28/16 at 9:17 AM with E8 (RN, UM) confirmed the lack of monitoring for the use of the antianxiety medication including the effectiveness, reason for use and non-pharmacological interventions. These findings were reviewed with E1 (NHA) and E2 on 7/28/16 at 1:50 PM.	F 329	medication and will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 24) DON or designee will complete random audits of PRN psychotropic medication administration to ensure that the documentation accurately reflects the resident's behavior prior to administration and the non-pharmacologic interventions trialed and failed prior to giving the medication and the effectiveness of the medication. Audit will include a random 10% of the facility population on a psychotropic medication and will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 27)		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		9/23/16	

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F 333	Continued From page 53 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (R52) out of 32 sampled residents were free from significant medication errors when Lasix was given at twice the ordered dose for over 5 months, for a total of 82 doses. Findings include: Review of R52's clinical record revealed: 1/27/16 - Handwritten admission physician orders for this 92-year old resident included Lasix 10 mg every other day for CHF. 2/2/16 POS showed Lasix 20 mg every other day instead of the 10 mg dose ordered by the physician. January, 2016 - July, 2016 MARs - R52 received the incorrect dose of Lasix every other day from 1/28/16 through 7/8/16 for a total of 82 doses. There was no evidence in the record that the nurse completing the 24 hour check on 1/28/16 or the pharmacist completing the medication review on 3/10/16 identified the discrepancy between ordered dose and dose entered in the computer. Side effects of Lasix include a decrease in sodium (normal 135 - 145), a decrease in potassium (normal 3.5 - 5.5) and an increase in kidney function tests - BUN (normal 7-20) and creatinine (normal 0.6-1.2). R52's blood results	F 333	F333 Corrective Measures for Resident Affected: There was no negative outcome to resident affected. R52's Lasix order was discontinued on 07/14/2016. The medication was resumed at the previous dose of 20mg on 07/27/2016. Identification of Others with the Potential to Be Affected: Facility residents have the potential to be affected. Nurse Managers completed an audit of the previous 30 days of physician orders to ensure that medications were transcribed correctly. (Exhibit 29) Measures to Prevent Recurrence: Licensed nurses received education on the best practice in regards to medication transcription. This education included the need to verify that the order is being transcribed on the right patient, for the right time, with the right medication, at the right dose, by the right route for the right duration. This education also included education on how to appropriately complete the 24 hour chart check. (Exhibit 1)		

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F 333	<p>Continued From page 54</p> <p>showed:</p> <p>- 4/29/16: Sodium 148, Potassium 4.1, BUN 26, Creatinine 0.9</p> <p>- 5/12/16: Sodium 144, Potassium 4.0, BUN 20, Creatinine 0.79</p> <p>7/14/16 - Resident returned from a five day hospital stay and Lasix was not re-ordered.</p> <p>During an interview with E6 (UM) on 7/26/16 at 11 :00 AM, the handwritten physician order and typed POS were reviewed. E6 confirmed that the dose for the Lasix was entered incorrectly into the computer on admission and that the medication was not re-ordered after the hospital admission. At 12:32 PM E6 told the surveyor that the physician was informed about the medication error and the physician would see the resident later today.</p> <p>7/27/16 - Review of E21's (Physician) progress note dated 7/26/16 discovered the physician acknowledged the medication dosing error and R 52 had 1+ ankle edema (sign of CHF). The physician would resume the Lasix at the 20 mg dose.</p> <p>During an interview with E9 (ADON) on 7/27/16 at 11:33 AM when asked how the pharmacy is informed of the medications ordered, E9 stated that the orders were entered in the computer. " We don't fax any more."</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p>	F 333	<p>Facility pharmacy will send a new orders report daily. This report will indicate new orders received from the pharmacy via electronic submission and will be compared to the physician orders in the chart by licensed nursing staff to ensure accurate transcription.</p> <p>Facility Nurse Managers will be pulling a new orders report from the EMR as a secondary system to ensure transcription accuracy. The Managers will sign off on the orders as correct and the information will be placed in QA.</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of medication transcription to ensure accuracy of order entry. The audit sample size will be 10% of the resident population will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100 % compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 28)</p>	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/ STORE DRUGS & BIOLOGICALS	F 431		9/23/16

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F 431	<p>Continued From page 55</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary 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 observation and interview, the facility failed to store drugs properly. Findings include:</p>	F 431	<p>F431</p> <p>Corrective Measures for Residents</p>		

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F 431	<p>Continued From page 56</p> <p>An observation was made on 7/21/16 at 11:40 AM of medications on a cart in the DON/ADON office. No personnel was in the office and the door was open. Medications observed include 4 bottles of MOM [Milk of Magnesia], 22 bottles of multi vitamins, 12 bottles of aspirin, 17 bottles of Colace, 12 bottles of Tylenol, 3 bottles of Senna Plus, and a bag of aspirin bottles.</p> <p>During an interview with E2 (DON) who entered the room just following the observation, E2 stated that these medications were purchased in bulk and were being sorted for distribution.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 7/28/16 at 1:50 PM</p>	F 431	<p>Affected: There was no negative outcome to residents affected. The bulk medications will no longer be sorted in the DON's office. Bulk medication have been placed in a locked closet.</p> <p>Identification of Others with the Potential to be Affected: Facility residents have the potential to be affected.</p> <p>An audit has been completed to ensure that medications are stored in secured, locked spaces only. (Exhibit 30)</p> <p>Measures to Prevent Recurrence:</p> <p>Facility has created a secured locked space to store bulk medications. Licensed nurses received education on the location of the locked closet and the need for all medications to be stored in a locked place</p> <p>Facility Licensed nurses received education on the need to store medications in secured areas only. (Exhibit 1)</p> <p>Monitoring of Corrective Measures: DON or designee will complete random audits of the facility environment to ensure that medications are being stored in locked spaces only. Audits will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100%</p>		

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F 431	Continued From page 57	F 431	compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 30)		
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their</p>	F 441		9/23/16	

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F 441	<p>Continued From page 58</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</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 process laundry in a way that prevents the spread of infection. Findings include:</p> <p>On tour with E9 (ADON) and E23 (Environmental Director) of the laundry area on 7/21/16 at 2:30 PM it was determined that the room for receiving, sorting and washing was under positive pressure and the room for drying and folding was under negative pressure. This caused the movement of the contaminated air from the dirty washing area toward the clean dryer room. Consequently, this did not prevent the transmission of infectious organisms.</p> <p>During an interview at the same time, E9 confirmed the findings, and explained that ventilation direction was not checked after the ventilation was turned off during recent roof repairs.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p>	F 441	<p>F441</p> <p>Corrective Measures for Resident Affected: The facility laundry room has been repaired to have negative pressure on the washing and sorting side, and positive pressure on the drying and folding side.</p> <p>Identification of Others with the Potential to be Affected: Facility Residents have the potential to be affected.</p> <p>Measures to Prevent Recurrence: Facility Environmental Service Director received one on one education related to infection control as it relates to processing laundry in a way that prevents the spread of infection. This included the need to have the drying and folding area to be under positive pressure, and the sorting and washing side to be under negative pressure. This education included techniques on testing the positive/</p>		

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F 441	Continued From page 59	F 441	negative pressure to ensure that the room is in compliance. (exhibit 11) Monitoring of Corrective Measures: Facility administrator or designee will complete random audits of facility laundry area to ensure that the positive and negative pressure in the room prevents the spread of infection. Audit results will occur on the following schedule: Daily until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 31)		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/ TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by : Based on observation and interview it was determined that the facility failed to have call bells functioning properly on 1 out of 3 units. Findings include: On 7/20/16 at 11:18 AM it was determined that	F 463	F463 Corrective Measures for Resident Affected: The call bell light in the bathroom of 301 has been repaired. The call bell light	9/23/16	

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F 463	<p>Continued From page 60</p> <p>activating the call light for the bathroom in room 301 did not cause the room's hall light to illuminate over the door for 301. The hall light over a door on another unit illuminated.</p> <p>During an interview with E15 (RN, UM) confirmed this finding, and she immediately put a bell in the room and contacted maintenance.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p>	F 463	<p>illuminates over the door of room 301.</p> <p>Identification of others with the potential to be affected:</p> <p>Facility residents have the potential to be affected.</p> <p>Facility Environmental Service Director completed an audit of facility room/ bathroom call lights to ensure that the light is correctly working with both sound and light outside of the appropriate room. (Exhibit 32)</p> <p>Measures to Prevent Recurrence: Facility Staff Members have received education on the importance of ensuring that call bells are functioning appropriately . This included the need for the call bell to both sound and illuminate outside the residents room. This education included the need to report all call bell issues to maintenance using the Tels system immediately. The education included the need to provide the resident with a hand bell if the call bell is noted to be malfunctioning. (Exhibit 1)</p> <p>Monitoring of Corrective Measures:</p> <p>Facility administrator or designee will complete random audits of facility rooms and bathrooms to ensure the call bells are functioning appropriately with the bell both sounding and illuminating outside of the residents room . The audit will be 10% of the resident rooms per audit and will occur on the following schedule: Daily</p>		

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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 07/28/2016
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 463	Continued From page 61	F 463	until 100% compliance is noted on 5 consecutive audits, three times a week until 100% compliance is noted for three consecutive weeks, weekly until 100% compliance is noted for three consecutive weeks and then monthly for three months or until such time that the facility feels that substantial compliance has been met. Audits will be forwarded to the facility Quality Assurance Committee. (Exhibit 32)		
F 469 SS=F	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</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 maintain an effective pest control program on 3 out of 3 units. Observations include seeing live flies and evidence of flies (residents having fly swatters close by). Findings include:</p> <p>During stage 1 (7/20/16 9:00 AM - 4:00 PM and 7 /21/16 8:00 AM - 4:00 PM), live flies were seen in rooms 202, 204, 211, 212, 221, 307, and 311. During this time live flies were also observed in hallways, dining areas and kitchen. Residents in rooms 307 and 311 had fly swatters within reach: one hanging on a walker and one hanging on the bed's side rail.</p>	F 469	<p>F469</p> <p>Corrective Measures for residents affected: There was no negative outcome to residents affected.</p> <p>Facility will continue to use Accurate Pest Control for its pest control program. The facility has a contract with the vendor for pest elimination to include a large fly program during the months of May through October.</p> <p>Identification of others with the potential to be affected:</p>	9/23/16	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 469	<p>Continued From page 62</p> <p>Observations during stage 2: 7/22/16 at 1:16 PM in Memory Unit dayroom, 7 flies on residents and furniture; 7/22/16 at 2:41 PM in room 212, one on bedside table, one in hallway; 7/25/16 at 9:20 AM in Memory Unit dayroom, 3 flies on residents and furniture; 7/25/16 at 9:30 AM in room 221, 5 flies in hallway, on furniture and on residents; 7/25/16 at 2:35 PM in room 311, 2 flies in room; 7/26/16 at 10:00 AM in room 221, 2 flies in room; 7/26/16 at 10:10 AM in room 311 both residents have fly swatters located close to their person.</p> <p>During an interview on 7/25/16 at 10:00 AM, E23 (Environmental Director) explained the facilities current pest control contract and procedures (which includes flies). Pest control company visits monthly and upon request and binders are located on each unit for recording pest sightings. Surveyor reviewed pest control records and logs of sightings. Issues with flies were not noted in any 2016 pest control records nor the employee logs.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/16 at 1:50 PM.</p>	F 469	<p>Facility Residents have the potential to be affected.</p> <p>Facility Environmental Service Director completed an audit of the physical plant to identify any areas of the exterior that could serve as an access point for flies to enter the building. This includes ensuring that there are no gaps to the outside, door curtains are functioning, and windows all have screens in place. (Exhibit 33)</p> <p>Measures to prevent recurrence:</p> <p>The facility nurse educator provided education to facility staff members on fly prevention. This included the need to keep the facility clean and free of food debris, ensuring fly lights are on at all times, closing doors to the exterior immediately instead of holding them open, and reporting any missing screens or damaged screens to maintenance along with reporting any noticed gaps to the exterior to maintenance. (Exhibit 1)</p> <p>The fly prevention program is on a preventative maintenance program through Accurate Termite and Pest Control. (Exhibit 34) It has also been added to the facility preventative maintenance program. (Exhibit 12)</p> <p>The facility will increase the number of visits completed by Accurate Pest Control during large fly season from one visit a month, to weekly visits. A fly curtain is also being installed at the main entrance</p>		

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F 469	Continued From page 63	F 469	<p>and the fly curtain on the smoking courtyard doors will be replaced with a larger device to cover both exterior doors. The fruit trees in front of the building have also been treated for flies.</p> <p>Monitoring of Corrective Measures:</p> <p>Facility administrator or designee will complete random audits of the physical plant to ensure that there are no gaps to the exterior that could serve as an access point for flies and that the physical plant is clean and free of spills and food debris that could serve as an attractant to flies. The audit sample size will be 5 patient care areas per audit and the sample areas will change with each audit. The audit will occur on the following schedule: Daily until 100% compliance is noted for three consecutive evaluations, then three times a week until such time 100% compliance is noted for three consecutive evaluations, then once a week until such time that 100% compliance is noted on three consecutive evaluations, then monthly for three months or until 100% compliance is noted on three consecutive evaluations. Audit results will be forwarded to the facility Quality Assurance Committee. (Exhibit 33)</p>		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center

DATE SURVEY COMPLETED: July 28, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced annual survey was conducted at this facility from July 20, 2016 through July 28, 2016. 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 81. The survey sample totaled thirty two (32).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed July 28, 2016: F161, F166, F246, F248, F253, F272, F278, F279, F280, F281, F309, F315, F323, F329, F333, F431, F441, F463, and F469.</p>	<p>Please cross-refer to facility Plan of Correction as outlined on CMS-2567.</p>	<p>9/23/2016</p>

Provider's Signature Deek, RN Title DN Date 8/26/16