

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

PRINTED: 03/10/2014
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 C 02/18/2014
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	INITIAL COMMENTS	F 000			
F 223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of facility investigative documents, it was determined that the facility failed to ensure that one resident (R10) of 11 sampled residents was free from sexual abuse by another facility resident (R11). Findings include:</p> <p>Cross Refer F323</p> <p>The following documentation was contained in the clinical record:</p> <p>8/30/13 - R11 signed a Behavior Contract that documented his agreement to demonstrate appropriate behavior toward R10. The Behavior</p>	F 223	<p>F-223</p> <p>Resident #11 was placed on 1:1 supervision</p> <p>Audits will be conducted by Director of Nursing or designee to determine if there are any other residents with inappropriate sexual behavior necessitating 1:1 supervision. Please refer to Attachment A.</p> <p>The root cause of the issue was the incident occurred between one of the every 15 minute checks ordered at the time and the facility failed to implement 1:1 supervision once the potential behaviors were again exhibited.</p> <p>System changes: Residents identified with inappropriate sexual behavior will be initially placed on 1:1 supervision and re-evaluated by interdisciplinary care plan team and psych services periodically and as needed to determine continuing need for 1:1 supervision.</p>	4/16/14	

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

TITLE

(X6) DATE

Administrative

3-31-2014

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 223	<p>Continued From page 1</p> <p>Contract further documented that R11 understood that he could not be alone with R10 at any time and that R10 was not able to be responsible for her actions. He also confirmed understanding that he would avoid inviting her to follow him.</p> <p>9/4/13- R10's Psychiatric Consultation by E12, Psychiatric Advanced Practice Nurse, revealed that R10 had moderate to severe dementia (The loss of mental functions such as thinking, memory, and reasoning) and is unable to give consent for sexual activity due to cognitive impairment. The recommendation advised placing R10 in a room with another female to avoid her feelings of loss from decreased visits.</p> <p>12/19/13 - R10's Quarterly Minimum Data Set (MDS) assessment documented R10 was severely impaired cognitively (act of knowing, perceiving and remembering).</p> <p>1/27/14- R10's care plan was initiated for resident preferences with an approach that the responsible person for R10 prefers that she be redirected away from R11.</p> <p>2/8/14 at 5:09 PM a nurses note documented that R11 (male resident) is noncompliant with staying away from R10's room and continued sitting in front of R10's room.</p> <p>2/8/14 - E10's, Certified Nurse's Aide's hand written incident statement documented that during rounds she entered R11's room and found R10 sitting on the bed performing a sexual act on R11 around 7:00-7:30 PM.</p> <p>The facility failed to ensure that R10 did not enter</p>	F 223	<p>Staff will be educated by nursing administration on process of reporting and initiating 1:1 supervision for residents identified with the potential for inappropriate sexual behavior. Please refer to Attachment B.</p> <p>Audits will be conducted by Director of Nursing or designee of residents with inappropriate sexual behavior and 1:1 supervision status daily times one week, then weekly x 4 then monthly x 3 and/or until 100% compliance is achieved on 3 consecutive reviews. Ongoing monitoring and follow up will occur in the morning clinical meeting. The results of the audits will be reported to the QA committee monthly for further follow up x 3 and as needed.</p>		

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F 223	Continued From page 2 R11's room and that R10 was not alone in the company of R11 on 2/8/14. The facility was aware that R10's responsible party did not want her alone with R11 and that R10 had moderate to severe dementia and was unable to give consent for sexual activity due to this cognitive impairment.	F 223			
F 272 SS=D	Findings reviewed with E1, Administrator and E2, Director of Nursing on 2/18/14 at approximately 11:30 AM. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272	F-272 Corrections were made to the MDS regarding the staging of the wound and the range of motion for resident #8 The root cause is rehab failed to provide documentation in a timely manner to the MDS coordinator. Nurse failed to stage the wound correctly. An audit will be conducted by Director of Nursing or designee of the pressure ulcers and compared with the documentation (wound assessments and MDS) to insure the staging of the pressure ulcers is accurate. Please refer to Attachment F. An audit will also be conducted on new admissions within the past 30 days regarding the residents' range of motion and will be compared with admission MDS assessment to insure information is accurate. Please refer to Attachment F.	4/16/14	

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F 272	<p>Continued From page 3</p> <p>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> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately assess one (R8) out of 11 sampled residents in the area of range of motion and was admitted to the facility with a stage III (skin has open sunken hole and or slough [yellow, tan dead tissue] in the wound bed) pressure ulcer (an area of skin that develops when the blood supply to it is cut off due to pressure). Findings include:</p> <p>The following documentation was contained in the clinical record:</p> <p>1a. 12/5/13- Physical Therapy assessed R8 and found the range of motion of the right lower and left lower extremities (legs) had a decrease in the normal range of motion.</p> <p>12/10/13- An admission Minimum Data Set (MDS) assessment incorrectly documented R8 had a normal range of motion of her extremities when she actually had a limitation in range of</p>	F 272	<p>The nursing staff will be educated by the wound nurse on wound staging and documentation as well as the appropriate treatment options based on the stage and condition of the pressure ulcers. The MDS coordinator now has access the rehabilitation company's EMR system to ensure documentation is collected in a timely manner.</p> <p>The wound assessment documentation and MDS documentation will be audited by director of nursing or designee weekly x 4 and then monthly x 3 and until 100% compliance is achieved on 3 consecutive reviews. Audits will be conducted by director of nursing or designee to determine the accuracy on new admission regarding the resident's range of motion and the admission MDS assessment weekly x 4, then monthly x 3 and until 100% compliance is achieved x 3 consecutive reviews. Results of the audits will be forwarded to the monthly QA committee x 3 and as needed</p>		

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F 272	Continued From page 4 motion. 2/10/14- An Interview with E6, Physical Therapist, at 12:50 PM revealed that the MDS was inaccurate and R8 had/has a limited range of motion of her right and left lower extremities. On 2/10/14 at approximately 12:48 PM an interview with E7, MDS Coordinator confirmed R8's MDS for 12/10/13 was inaccurate and that the limitation for range of motion on both sides should have been documented on the MDS. 1b. Cross refer F314, example #1 R8 was admitted to the facility on 12/3/13 with a stage III pressure ulcer. 12/10/13- An admission Minimum Data Set (MDS) assessment incorrectly documented that R8 had a stage II pressure ulcer (skin blisters or skin forms an open sore. The area around the sore may be red and irritated) instead of the actual stage III pressure ulcer. On 2/12/14 an e-mail from E11, Corporate Medical Director confirmed that R8 was admitted from the hospital with a stage III pressure ulcer not a stage II pressure ulcer. The above findings were reviewed on 2/18/14 at approximately 11:30 AM with E1, Administrator and E2, Director of Nursing.	F 272			
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	F 280	F-280 Resident #8's care plan was revised to include the air mattress.	4/16/14	

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F 280	<p>Continued From page 5</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise the care plan for one (R8) out of 11 sampled residents. Findings include:</p> <p>R8 was admitted with a pressure ulcer (an area of skin that develops when the blood supply to it is cut off due to pressure).</p> <p>The following documentation was contained in the clinical record:</p> <p>12/4/13- A care plan was developed for impaired skin integrity related to skin breakdown as evidence by sacral (lower back) wound present upon admission with interventions that included to complete skin sheet with bath and notify nurse of</p>	F 280	<p>An audit will be conducted of the resident's air mattresses by Director of Nursing or designee and compared with the care plan to insure consistency. Please refer to Attachment C. Care plans will be revised as needed to reflect the air mattresses.</p> <p>The root cause of the issue is the nurse failed to update the care plan when the air mattress was ordered.</p> <p>Nursing staff to be educated by nursing administration to insure that when an air mattress is ordered that the care plan is updated to reflect the air mattress.</p> <p>Orders from the previous day will be reviewed and monitored in the morning clinical meeting to insure care plan updates occur.</p> <p>Air mattress orders and care plan documentation will be audited by Director of Nursing or designee daily x 1 week, then weekly x 4 then monthly x 3 and/or when 100% compliance has been achieved on 3 consecutive reviews. The results of the audits will be reported to the QA committee monthly x 3.</p>		

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F 280	Continued From page 6 abnormal findings, dietician review as needed, administer medication, licensed nurse skin assessment every week, keep skin clean and dry. 12/6/13- A care plan was developed for a pressure ulcer with interventions that included communicate to care givers reason for pressure ulcer development, turn and reposition every 2 hours with skin checks, distribute weight evenly and off of bony prominence's using pillow or other devices to reduce contact and float heels while in bed. 2/6/14- R8 was observed at 10:35 AM in bed lying on a air mattress. Review of R8's care plan failed to include the use of an air mattress. On 2/10/14 at approximately 11:00 AM review of R8's care plan with E5, Registered Nurse Unit Manager, confirmed the facility failed to review and revise R8's care plan to include the use of an air mattress.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	F-309 Unable to correct the deficiency for resident #4. An audit will be conducted by Director of Nursing or designee of all new admission charts from February 18, 2014 to March 13, 2014 to determine the timeliness of medications ordered and administered upon admission as well as the documentation of necessary vital signs prior to medication administration. Please refer to Attachment D.	4/16/14	

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F 309	<p>Continued From page 7</p> <p>Based on record review and interview it was determined that the facility failed to administer medications as ordered by the physician in the plan of care and failed to assess vital signs before administering medications as ordered for one (R4) out of 11 sampled residents. Findings include:</p> <p>The following documentation was contained in the clinical record:</p> <p>1/22/14- R4 was admitted to the facility.</p> <p>1/22/14- Physician medication order that included Coreg (for high blood pressure) twice daily hold for systolic blood pressure (the top number of blood pressure that reflects pressure in vessels when the heart is beating) below 100 or heart rate below 60, Lasix (water pill), Digoxin each evening for atrial fibrillation (irregular heartbeat), Apresoline every 8 hours for high blood pressure, Remeron at bedtime for depression and Flagyl every 8 hours for 7 days for infection</p> <p>1/23/14- Nurse's note documented R4 was admitted to the facility on 1/22/14 at 7:30 PM.</p> <p>1/22/14- Medication Administration Record (MAR) documented R4 received Lasix at 8:00 PM and Flagyl at 10:00 PM. Digoxin was available in the Med Dispense station list at the facility but was not administered.</p> <p>1/22/14- Nurses notes documented Digoxin administered at 1:10 AM as medication was not available until 11:00 PM on 1/22/14 heart rate was 80 beats per minute. However, the facility failed to administer R4's evening dose of Coreg and Apresoline as ordered by the physician.</p>	F 309	<p>The root cause of the issue is the nurse failed to check the med dispense prior to determining that the medication was unavailable. The nurse also failed to obtain vital signs prior to giving the medication as well as notifying the physician of unavailable medications.</p> <p>System change: Facility has a contract with a local back up pharmacy (Coastal pharmacy) to obtain medications as needed when Remedi pharmacy cannot provide medications in the time frame needed. A vital sign report will be reviewed daily to insure the blood pressures are completed and documented with medications as ordered. Medication administration policy/procedure updated to include the nurses to check the medications dispense system, notification of the MD/NP and use of back up pharmacy.</p> <p>Nursing staff will be educated by nursing administration on medication policy/procedure regarding checking the in house medication dispense box, the procedure for the back up pharmacy (Coastal pharmacy) and Physician/NP notification when meds are unavailable. The nurses will also be educated by nursing administration on medications requiring vital sign parameters prior to administration and documentation procedures</p> <p>Audits will be conducted on compliance of the procedures to include use of med dispense system, back up pharmacy and physician notification of unavailable meds, daily x one week, weekly x 4 and monthly x 3 and until 100% compliance is achieved x 3 consecutive reviews</p>		

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F 309	Continued From page 8 1/23/14- MAR documented at 7:06 AM that R4 did not receive Flagyl or Apresoline, as the medications were not available. However, according to the Med Dispense station list the Flagyl was available in the station. 1/23/14- MAR documented at 9:22 AM that the Coreg was administered but the facility failed to assess R4's blood pressure and heart rate to ensure the residents blood pressure and heart rate were within the parameters for safe administration of this medication. 1/23/14- MAR documented at 10:21 PM Remeron was not administered as the medication was not received by the facility. 1/24/14- MAR documented at 9:36 PM Remeron was not administered as the drug was not received. 1/25/14- MAR documented at 7:34 PM Coreg was administered but the facility failed to assess R4's blood pressure and heart rate to ensure the resident's blood pressure and heart rate were within the parameters for safe administration of this medication. The facility failed to administer medications to R4 according to the plan of care. The facility failed to consistently assess blood pressures and pulses to ensure these vital signs met the proper parameters to ensure R4 could safely be administered these medications. The facility failed to notify the physician that these medications were not available for administration. The facility failed to identify medications that were available to them in their Med Dispense station.	F 309	Ongoing compliance will be reviewed during the morning clinical meeting. Results of the audits will be reported to the monthly QA committee monthly x 3 and as needed.		

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F 309	Continued From page 9	F 309		
F 312 SS=D	<p>Review of R4's clinical record with E2, Director of Nursing on 2/10/14 at 12:20 PM confirmed the facility failed to administer R4's medications as ordered and failed to assess the vital signs as needed prior to the administration of medications.</p> <p>Findings were reviewed with E1, Administrator and E2, Director of Nursing on 2/11/14 at approximately 1:00 PM.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of 9 residents sampled, the facility failed to provide the necessary services to maintain good personal hygiene related to R1's fingernails. Findings include:</p> <p>The following documentation was contained in the medical record;</p> <p>4/4/11 - Care plan documented a self-care deficit that was related to a history of a cerebral vascular accident (stroke) . This care plan was updated 1/9/14 and included approaches such as encourage self-care and provide assistance as needed, including setting up supplies as needed.</p>	F 312	<p>F-312 Resident #1's nails were cleaned and trimmed.</p> <p>Audit will be conducted by Director of Nursing or designee of the physician's orders for nail care as well as the condition of the resident's nails. Please refer to Attachment E.</p> <p>The root cause is the nursing staff failed to follow physician's orders for nail care.</p> <p>System change: Review physician orders for nail care. Reinforce existing nail care policy for daily care and as needed. Restorative aides will increase nail observation of the residents from every 2 weeks to every week ongoing.</p> <p>The nursing staff will be educated by nursing administration regarding nail care policies and following physician's orders. The resident's nails and nail care orders will be monitored daily x one week, then weekly x 4 and then monthly x 3 and until 100% compliance is achieved on 3 consecutive reviews. The results of the audits will be reported to the monthly QA committee monthly x 3.</p>	4/16/14

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F 312	Continued From page 10 12/9/13 - Quarterly Minimum Data Set assessment documented R1 was totally dependent for hygiene and bathing. 1/2/14 - Physician's order stated to monitor nails every shift and to trim and file as needed. 2/10/14- Observation at approximately 1:00 PM of R1 revealed nails with debris under the edges and also jagged edges in need of a trim. 2/10/14 - Interview at approximately 1:10 PM with E3, Assistant Director of Nursing and Wound Care Nurse observed and confirmed R1's nails were not clean and the edges were jagged. 2/12/14 - Observation at approximately 12:00 PM revealed nails with debris under the edges and also jagged edges in need of a trim. The facility failed to maintain good personal hygiene related to R1's fingernails. R1's nails were observed with debris underneath of them and also jagged and in need of trimming. Findings were reviewed with E1, Administrator and E2, Director of Nursing on 2/11/14 at approximately 1:00 PM.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314	F-314 Unable to correct the documentation on 12/5/13, 12/6/13, 12/10/13, 12/25/13 and 1/28/13 regarding the staging of the wound for resident #8. Resident #1's heels were floated using pillows	4/16/14	

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F 314	<p>Continued From page 11</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedures, interviews, and observations, it was determined that the facility failed to ensure that two residents (R8 and R1) out of 11 sampled residents who had a pressure ulcer (An area of skin that develops when the blood supply to it is cut off due to pressure) received the necessary treatment and services to promote healing and prevent new pressure ulcer from developing. The facility also failed to ensure they correctly identified the stage of R8's pressure ulcer. Findings include:</p> <p>The facility's policy and procedure for Pressure Ulcer Prevention documented the following interventions that will be completed for residents who are at risk for pressure ulcer development or that are receiving treatment for pressure ulcers will be turned and repositioned at least every two hours or more frequently depending on other risk factors, use pillows or wedges to prevent bony prominences from direct contact with each other ...elevate heels off of the bed ...maintain the head of the bed at the lowest degree of elevation ...</p> <p>1. R8 was admitted on 12/3/13. The transferring facility documented R8 had a stage III pressure ulcer (skin has open sunken hole and or slough [yellow, tan dead tissue] in the wound bed), however the facility continuously documented this wound as a stage II pressure ulcer (skin blisters</p>	F 314	<p>An audit will be conducted by Director of Nursing or designee of the pressure ulcers and compared with the documentation (wound assessments and MDS) to insure the staging of the pressure ulcers are accurate. Please refer to Attachment F. An audit will also be conducted of residents with orders for floating heels and observe residents to determine compliance with the orders. Please refer to Attachment F.</p> <p>Root cause is lack of knowledge on the part of the nurse regarding staging of pressure ulcers. The nursing staff failed to float the heels and turn and reposition consistently as ordered. The incorrect documented staging of the ulcer led to incorrect documentation on the MDS.</p> <p>System change: Frequent rounds by nursing administration/supervisors to include observation of floating heels and turning and repositioning and addressing with staff as needed. The correct wound sheet documentation will lead to correct MDS's. The nursing staff will be educated by the wound nurse on wound staging and documentation.</p> <p>The nursing staff will also be educated on turning and repositioning and floating heels per the care plan by nursing administration. The wound assessment documentation and MDS documentation will be audited weekly x 4 and then monthly x 3 and until 100% compliance is achieved on 3 consecutive reviews. The compliance with turning and repositioning and floating heels will be audited daily x 1 week, then weekly x 4, then monthly and until 100% compliance is achieved on 3 consecutive reviews.</p>		

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F 314	<p>Continued From page 12</p> <p>or skin forms an open sore. The area around the sore may be red and irritated).</p> <p>The following documentation was contained in the clinical record:</p> <p>12/4/13- Care plan for impaired skin integrity related to skin break down as evidenced by sacral (lower back) wound present upon admission with interventions that included to complete skin sheet with bath and notify nurse of abnormal findings, licensed nurse skin assessment every week. Keep skin clean and dry.</p> <p>12/4/13- Physician order was written to turn and reposition R8 every two hours with skin checks.</p> <p>12/5/13-The Treatment Assessment Report (TAR) documented a pressure ulcer located on the lower back 5.0 cm. (centimeters) x 2.0 cm. x 0.1 cm. and incorrectly staged it as a stage II pressure ulcer with pink granulation (healthy) tissue.</p> <p>12/6/13- A second care plan was developed for pressure ulcer, (that incorrectly identified the pressure ulcer as an actual stage II instead of a stage III) upon admission to facility on 12/3/13 with interventions that included communicate to care givers reason for pressure ulcer development, turn and reposition every 2 hours with skin checks, distribute weight evenly and off of bony prominences using pillow or other devices to reduce contact and float heels (elevate to relieve pressure) while in bed.</p> <p>12/10/13- TAR documented a pin point area of white slough in center of the wound bed with pink</p>	F 314	Results of the audits will be forwarded to the monthly QA committee x 3 and as needed.		

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F 314	<p>Continued From page 13</p> <p>granulation tissue 4.5 cm. x 2.0 cm. x 0.1 cm. and documented the wound had improved. Even though the pressure ulcer was observed with slough the facility failed to identify this wound as a stage III pressure ulcer.</p> <p>12/10/13- Admission Minimum Data Set (MDS) assessment documented that R8 required one person to assist with bed mobility and incorrectly documented R8 was admitted with a stage II pressure ulcer instead of a stage III.</p> <p>12/25/13 through 1/30/14 this pressure ulcer was measured weekly, assessed with pink granulation tissue and no slough. However, this wound was still incorrectly documented as a stage II pressure ulcer.</p> <p>1/28/14- MDS incorrectly documented R8 had a stage II pressure ulcer.</p> <p>2/5/14- TAR documented the pressure ulcer measured 2.0 cm. x 2.1 cm. x 0.1 cm. and that the wound bed had moist pink granulation tissue present. It continued to document on the TAR that the wound had less discoloration noted at margin of the wound bed. Periwound (skin around the wound) is pink and blanchable (redness fades when the skin was touched) and firm to touch.</p> <p>2/6/14- At approximately 10:35 AM and 11:05 AM, R8 was observed lying in bed on her back with her heels lying on the bed not suspended off the bed to prevent pressure.</p> <p>2/6/14- At approximately 11:55 AM. R8 was observed in the same position. R8 stated no one had been in to change her position.</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>2/6/14- At approximately 12:20 PM, R8 was observed sitting up in bed eating lunch still on her back with her heels on the bed not floated.</p> <p>2/6/14- At approximately 1:20 PM, R8 was observed lying in bed on her back (not repositioned) with her heels lying on the bed not off loaded/suspended off the bed</p> <p>2/6/14- At approximately 1:50 PM, R8 was observed in same position on her back with her heels on the bed not floated. R8 stated staff would be in to change her position later.</p> <p>2/7/14- At approximately 10:35 AM, 11:45 AM, 12:50 PM, and 1:35 PM, R8 was observed lying in bed on her back with her heels lying on the bed not off loaded/suspended off the bed to prevent pressure</p> <p>On 2/7/14 surveyor requested E2, Director Of Nursing, at approximately 1:38 PM, to observe R8's position in bed. E2 confirmed resident's heels were on the bed and not floated as indicted in R8's plan of care. E2 assessed R8's heels and noted they were red.</p> <p>On 2/7/14 at 1:40 PM an observation of R8's wound was observed with E2. Upon observation R8's wound contained slough in the wound bed and the wound bed was a beefy red. E2 stated that R8 had a stage III pressure ulcer with slough. E2 left the room and instructed E8, Registered Nurse to redress R8's wound. No wound measurements were completed and E2 failed to notify the physician of her observations.</p> <p>An interview with E8, RN on 2/7/14 at 2:15 PM</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>revealed E8 redressed the wound using the existing physician order. When questioned about the slough E8 stated he would contact the physician to look at the wound and see if he wanted a different dressing.</p> <p>On 2/7/14 at approximately 2:40 PM, E4, Physician observed the wound and stated the pressure ulcer had slough and required chemical debridement.</p> <p>On 2/7/14 a physician order was written to change the pressure ulcer treatment to cleanse the wound with normal saline, pat dry, apply Solosite (a gel used to create a moist wound environment) cover with dry dressing twice a day. Apply skin prep (a liquid film forming dressing to help reduce friction) to bilateral heels twice a day.</p> <p>On 2/10/14 at 10:30 AM R8's wound was observed with E3, Assistant Director of Nursing/Wound Nurse, that revealed the wound bed was red and measured 2.4 cm. x 1.8 cm. x 0.1 cm. with 20% slough, light blood tinged drainage and the edges of wound were macerated. The surrounding tissue was purple and maroon in color. E3 confirmed observation stated the wound had gotten worse since she assessed it on 2/5/14. However, the 2/10/14 wound sheet documented the surrounding tissue was pink not purple and maroon as observed and confirmed during the wound observation.</p> <p>The facility failed to correctly identify the pressure ulcer as a stage III despite the TAR dated 12/10/13 that documented slough was observed in the wound. The facility failed to contact the physician about the dressing change and the wound observation until the surveyor questioned</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>the facility. The facility failed to follow the plan of care to turn and reposition R8 every two hours. The facility failed to suspend R8's heels off the bed as ordered and care planned that led to the physician order for skin prep to R8's heels.</p> <p>Findings were reviewed with E1, Administrator, E2, Director of Nursing, E3 Assistant Director of Nursing/Wound Nurse on 2/11/14 at 1:00 PM.</p> <p>On 2/12/14 at 12:15 PM, R8 was observed in her bed and her heels were lying on the bed and not off loaded. Two staff members were immediately notified.</p> <p>2.R1 was re-admitted to the facility on 3/27/11.</p> <p>The following documentation was contained in the clinical record:</p> <p>6/8/11- Care plan initiated and then last updated 1/28/14 for prevention and treatment of related pressure ulcers related to decreased mobility. The approaches included distributing weight evenly floating/off-loading (suspending heels off mattress to relieve pressure) heels while in bed, limit sitting in wheelchair to less than 2 hour intervals and turning and repositioning every hour side to side using wedge cushion.</p> <p>12/9/13- Quarterly Minimum Data Set (MDS) assessment documented R1 required extensive assistance of two persons for bed mobility and was totally dependent for activities of daily living such as dressing and bathing.</p> <p>1/29/14- Wound Documentation Tracking Tool documented the wound type as full thickness area with abscess (collection of fluid under the</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>skin) to left buttock and surface area healed. The size was documented as open area circular 1.0 cm by 1.4 cm by 3.0 cm with 2 areas of tunneling noted.</p> <p>2/6/14- At 11:20 AM, R1 was observed sitting in her wheelchair in her room. R1 was also observed at 12:00 PM and then again at 1:50 PM sitting in her wheelchair. At 1:50 PM staff put R1 in her bed to receive wound care.</p> <p>2/7/14- At 10:30 AM, R1 was observed lying in bed on her back with a blue wedge cushion (used to position resident on her side) lying on the bed next to R1's left shoulder. (The wedge was not being used to position R1). R1's heels were lying on the bed instead of being suspended off the bed to relieve pressure. R1 was observed in the same position with the same wedge cushion at her left shoulder at 11:30 AM, 12:45 PM and at 2:00 PM (approximately 3 1/2 hours).</p> <p>2/7/14- Interview at approximately 2:30 PM with R1's family member who stated she entered R1's room at 11:30 AM and has not left her room. R1's family member confirmed the resident had not been turned or repositioned since she arrived (approximately 3 hours).</p> <p>2/10/14- At 3:00 PM, R1 was observed lying in bed with her heels on the bed and not off loaded/floating to prevent pressure. E9, Licensed Practical Nurse observed and confirmed this observation.</p> <p>The facility failed to provide care and services to promote healing for R1 by not following the plan of care that included turning and repositioning R1 every hour side to side using a wedge cushion,</p>	F 314			

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F 314	Continued From page 18 distributing weight evenly and over boney prominences by using pillows and wedge cushions, off-load heels while in bed and to limit sitting in wheelchair to less than two hour intervals. Findings reviewed with E1, Administrator and E2, Director of Nursing on 2/11/14 at approximately 1:00 PM.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide adequate supervision for one (R11) out of 11 sampled residents to prevent resident to resident sexual abuse. Findings include: Cross refer F223 R11 (Male) and R10 (Female) were residents in the facility. The following documentation was contained in the clinical record: 7/27/13- Quarterly Minimum Data Set (MDS) assessment documented R11 was alert and	F 323	F-323 Resident #11 was placed on 1:1 supervision Audits will be conducted by Director of Nursing or designee to determine if there are any other residents with inappropriate sexual behavior necessitating 1:1 supervision. Please refer to Attachment A. The root cause of the issue was the incident occurred between one of the every 15 minute checks ordered at the time and the facility failed to implement 1:1 supervision once the potential behaviors were again exhibited. System changes: Residents identified with inappropriate sexual behavior will be placed on 1:1 supervision initially and re-evaluated by interdisciplinary care plan team and psych services to include a review of nurses and social services notes periodically and as needed to determine the continuing need for 1:1 supervision. Please refer to Attachment B.	4/16/14	

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F 323	<p>Continued From page 19</p> <p>oriented and was able to make his own decisions.</p> <p>8/30/13- Social Service Progress Note at 4:31 PM documented that the Social Worker met with R11 to discuss his behaviors with R10. R10 was found in his room and it is believed they had a sexual encounter. R10 had a decline in cognition (act of knowing, perceiving and remembering) and is not able to think before she acts. R11 is cognitively intact. R11 has signed a behavior contract that he is not to see R10 alone (unsupervised). R10 is not to go in his room. They may talk in public but not alone.</p> <p>8/30/13- Physician order for every 15 minute checks on R11.</p> <p>9/3/13- Physician order for psychiatric evaluation and treatment for R11.</p> <p>9/4/13- Social Service Progress Note documented at 12:00 PM that R10 and R11 could visit each other but no sexual acts or be alone in a room, R11 agreed.</p> <p>9/15/13- Nurse's note documented at 11:40 PM resident on 1:1 for behaviors (trying to meet with R10 alone). .</p> <p>9/16/13- R11's nurse's note documented at 2:19 PM resident alert and oriented to person, place and time. R11 continued to be on 1:1 supervision related to behaviors.</p> <p>9/17/13- Nurse's note documented at 11:10 PM resident remains on 1:1 for behaviors.</p> <p>9/18/13- Social Service Progress Note documented at 1:49 PM that the Social Worker</p>	F 323	<p>Staff will be educated by nursing administration on process of reporting and initiating 1:1 supervision for residents identified with the potential for inappropriate sexual behavior.</p> <p>Audits will be conducted by Director of Nursing or designee of residents with inappropriate sexual behavior and 1:1 supervision status daily times one week, then weekly x 4 then monthly x 3 and/or until 100% compliance is achieved on 3 consecutive reviews. Ongoing monitoring and follow up will occur in the morning clinical meeting. The results of the audits will be reported to the QA committee monthly for further follow up x 3 and as needed.</p>		

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F 323	<p>Continued From page 20</p> <p>met with R11's daughter who stated since he had a stroke he was not the same. When he was home he would masturbate in front of her. She took him to the hospital. The hospital staff told the daughter, R11 could not return home with her because she was disabled and could not defend herself. So he agreed to be admitted to the facility.</p> <p>9/20/13- R11 had a care plan initiated for behavior of inappropriately touching of opposite sex with a goal that the resident will comply with redirection when exhibiting inappropriate behavior with interventions that included implement limit setting using taped lines, staff supervision, redirection and explanation to resident, intervene and redirect when inappropriate behavior is observed, consult physician and family.</p> <p>9/23/13- Psychiatrist wrote an order to "discontinue 1:1 observation status. R11 has been given verbal cues to decrease entering other clients areas. Staff will be in serviced on verbal interventions."</p> <p>10/8/13- Social Service Progress Note documented at 2:55 PM, R11 was seen by psychiatry as resident has displayed inappropriate behavior of a sexual nature (with R10). Resident is accepting of his part and trying to stay away from the other resident (R10). Psychiatry suggested that he watch comedy shows on TV.</p> <p>10/8/13- Social Service Progress Note documented at 4:06 PM, that she met with R11's daughter and discussed some concerns concerning her dad's behavior. Together the Social Worker and daughter met with R11 to discuss concerns of him going back into his old</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>patterns. Social Worker explained to R11 she did not want to see him get into trouble. He agreed to be more careful and stay away from R10.</p> <p>10/11/13- Psychiatry Progress note documented R11 was oriented to person, place, time and situation. R11 was also prescribed Paxil (antidepressant) 20 mg. every night at bed time and Benadryl (used for allergies and inability to sleep) 25 mg by mouth a bedtime for insomnia (inability to sleep).</p> <p>10/22/13- Annual MDS documented R11 was alert and oriented and could make decisions.</p> <p>11/22/13- Social Service Progress Note documented at 4:07 PM that she spoke with R11 concerning his relationship with another resident (R10). R11 was told to discourage R10 from following him. He stated he did not want to see her because he knows she has dementia and he could get into trouble.</p> <p>12/5/13- Psychiatric evaluation documented R11 was referred for maladaptive behaviors. The evaluation documented that R11 felt like he was being watched all the time and he did not like it nor did he like the facility telling him what to do.</p> <p>12/10/13- Social Service Progress Note documented at 4:29 PM resident seen by psychologist due to his manipulative behavior.</p> <p>12/12/13- Psychiatric evaluation documented R11 was referred for his depressive symptoms. R11 indicated that he could not stand not seeing R10 much longer.</p> <p>12/13/13- Social Service Progress Note</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>documented at 1:16 PM R11 was seen by psychologist. R11 stated he is upset that he cannot see his girlfriend (R10).</p> <p>12/16/13- Social Service Progress Note documented at 3:04 PM met with R11 to discuss his behavior with another resident (trying to meet with R10). He denied having any sexual contact with anyone. He stated they were just talking. Explained he cannot be any where around the other resident (R10). Reminded him that the police can be contacted. Reinforced the seriousness of this matter.</p> <p>12/19/13- Physician order for every 15 minute checks for R11. Clarification of this order with E2, DON on 2/7/14 at approximately 10:30 AM revealed the facility felt that R10 was seeking R11 and he did not discourage it so he was put on every 15 minute checks.</p> <p>1/26/14- Social Service Progress Note documented at 1:26 PM R11 was doing better but still has a problem with not seeing other resident (R10).</p> <p>1/27/14- R10's care plan was initiated for resident preferences with an approach that the responsible person for R10 prefers that she be redirected away from R11.</p> <p>2/8/14- Nurse's notes documented at 5:09 PM, R11 non compliant with staying away from R10 and continues sitting in front of R10's room. There was no evidence that the facility tried to increase monitoring of R11 to prevent him from approaching R10.</p> <p>2/8/14 - E10's, Certified Nurse's Aide (CNA),</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>hand written incident statement documented that during rounds she entered R11's room and found R10 sitting on the bed performing a sexual act on R11 around 7:00-7:30 PM.</p> <p>2/9/14- Nurse's note (late entry for 2/8/14) at 10:30 PM was informed that R11 was found in his room with another resident (R10 who is prohibited from being behind closed doors with R11) at 7:30 PM when the CNA entered R11's room to do her every 15 minute checks. R11 was redirected and the prohibited resident (R10) was escorted to an appropriate location.</p> <p>2/9/14- R11 had a care plan initiated for noncompliance related to seeking out unsupervised time with resident who does not have cognitive function to consent to physical intimate behavior with interventions that include praise and 1:1 at all times. A note documented on the care plan stated 2/9/14 resident found to be in room during a physically intimate encounter with a resident who does not have consensual cognitive function.</p> <p>On 2/12/14 at approximately 10:30 AM review of nurses note dated 9/15/13 with E2, Director of Nursing (DON) on 2/7/14 at approximately 10:30 AM revealed that R11 and R10 were found in the back hall, that leads to the laundry, fondling each other. R10 had her hand up R11's shorts and R11 had his hands fondling between R10's legs</p> <p>On 2/12/14 at approximately 2:00 PM review of the incident with E1, Administrator and E2, Director of Nursing concerning the sexual abuse between R11 and R10 revealed that when R10 was cognitively intact R10 and R11 were seeing each other. They would talk, walk the halls and sit</p>	F 323			

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F 323	Continued From page 24 together. They have been together for about three years. When the facility identified R10 had a decrease in cognition the family decided they did not want R10 or R11 be alone. Even though R11 was on every 15 minute checks and had a behavioral contract the facility failed to provide adequate supervision for R11 when he was displaying behaviors of noncompliance with staying away from R10, who is severely cognitively impaired. Due to the lack of adequate supervision R11 encouraged R10 to perform a sexual act on him. Findings reviewed with E1, Administrator and E2, DON, on 2/18/14 at approximately 11:30 AM.	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F-425 Unable to correct the deficiency for resident #4. An audit will be conducted by Director of Nursing or designee of all new admission charts from February 18, 2014 to March 13, 2014 to determine the timeliness of medications ordered and administered upon admission as well as the documentation of necessary vital signs prior to medication administration. Please refer to Attachment D. The root cause of the issue is the nurse failed to check the med dispense prior to determining that the medication was unavailable. The nurse also failed to obtain vital signs prior to giving the medication as well as notifying the physician of unavailable medications.	4/16/14	

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F 425	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to obtain medications according to the plan of care and physician order for one (R4) out of 11 sampled residents. Findings include: Cross refer F309 R4 was admitted to the facility on 1/22/14. The following documentation was contained in the clinical record: 1/22/14- R4's physician medication order that included Coreg (for high blood pressure) twice daily hold for systolic blood pressure (the top number of blood pressure reflects pressure in vessels when the heart is beating) below 100 or heart rate below 60, Lasix (water pill), Digoxin each evening for atrial fibrillation (irregular heartbeat), Apresoline every 8 hours for high blood pressure, Remeron at bedtime for depression and Flagyl every 8 hours for 7 days for infection 1/23/14- Nurse's note documented R4 was admitted to the facility on 1/22/14 at 7:30 PM. 1/22/14- Nurses notes documented Digoxin administered at 1:10 AM as medication was not available until 11 PM on 1/22/14 heart rate was 80 beats per minute. However, the facility failed to administer R4's evening dose of Coreg and Apresoline as ordered by the physician. The	F 425	System change: Facility has a contract with a local back up pharmacy (Coastal pharmacy) to obtain medications as needed when Remedi pharmacy cannot provide medications in the time frame needed. A vital sign report will be reviewed daily to insure vital signs are completed and documented with medications as necessary. Medication administration policy/procedure updated to include the nurses to check the medications dispense system, notification of the MD/NP and use of back up pharmacy. Nursing staff will be educated by nursing administration on medication policy/procedure regarding checking the in house medication dispense box, the procedure for the back up pharmacy (Coastal pharmacy) and Physician/NP notification when meds are unavailable. The nurses will also be educated by nursing administration on medications requiring vital sign parameters prior to administration and documentation procedures. Audits will be conducted on compliance of the procedures to include use of med dispense system, back up pharmacy and physician notification of unavailable meds, daily x one week, weekly x 4 and monthly x 3 and until 100% compliance is achieved x 3 consecutive reviews. Ongoing compliance will be reviewed during the morning clinical meeting. Results of the audits will be reported to the monthly QA committee monthly x 3 and as needed.		

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F 425	<p>Continued From page 26</p> <p>facility failed to contact pharmacy services to obtain these medications.</p> <p>1/23/14- Medication Administration Record (MAR) documented at 7:06 AM that R4 did not receive Flagyl or Apresoline, as the medications were not available. However, according to the Med Dispense station list the Flagyl was available in the station. The facility failed to contact pharmacy services to obtain the Apresoline.</p> <p>1/23/14- MAR documented at 10:21 PM Remeron was not administered as the medication was not received by the facility. The facility failed to contact a pharmacy in order to obtain these medications.</p> <p>1/24/14- MAR documented at 9:36 PM that the Remeron was not administered as the drug was not received. The facility failed to contact a pharmacy in order to obtain these medications.</p> <p>On 2/7/14 at 12:45 PM an interview with E5, Registered Nurse revealed if the medication orders are in the computer system by 5:00 PM, the medications will arrive at the 11:00 PM delivery. If the orders are not in the system by 5:00 PM, the medications do not arrive until the next day. If the pharmacy is called to delivery medications it is a 4 hour drive to deliver the medications from the facility's pharmacy company that is located in another state.</p> <p>On 2/7/14 at 2:40 PM interview with E2, Director of Nursing confirmed E5's statement. E2 stated they do not use a local 24-hour pharmacy for the facility to obtain medications after hours.</p> <p>The facility failed to ensure medications were</p>	F 425			

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F 425	<p>Continued From page 27</p> <p>available for administration to R4. The facility failed to contact a pharmacy service in order to obtain the necessary medications for R4.</p> <p>Findings were reviewed with E1, Administrator and E2, Director of Nursing on 2/11/14 at approximately 1:00 PM.</p>	F 425		
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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

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NAME OF FACILITY: Delmar Nursing and Rehab

DATE SURVEY COMPLETED: February 18, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from February 5, 2014 through February 18, 2014. The deficiencies cited in this report are based on record reviews, staff and resident interviews, and review of other documentation as indicated. The facility census the first day of the survey was 80. The sample size included eleven (11) residents.</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:</p>	<p>Please refer to CMS 2567-L survey Completed February 18, 2014. F223, F272, F280, F309, F312, F314, F323, F425</p>

Provider's Signature

Title

Administrator

Date

3-31-2014



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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STATE SURVEY REPORT

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	Cross refer to the CMS 2567-L survey completed February 18, 2014. F223, F272, F280, F309, F312, F314, F323, F425	
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Provider's Signature

Title

Administrator

Date

3-31-2014