

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

PRINTED: 03/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/29/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from February 18, 2016 through February 29, 2016. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 83. The survey sample totaled thirty two (32).</p> <p>Abbreviations/Definitions used in this 2567 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;          RNAC - Registered Nurse Assessment Coordinator;          CNA - Certified Nurse's Aide;          FSD - Food Service Director;          RD - Registered Dietitian;          NP - Nurse Practitioner;          PA - Physician Assistant;          FMD - Facility Maintenance Director;          ADLs (Activities of Daily Living) - such as bathing and dressing;          BM - Bowel Movement;          eMAR - Electronic Medication Administration Record (in the computer);          F (Fahrenheit) - temperature scale;          HS - at bedtime;          MAR - Medication Administration Record (on paper);          mg (milligram) - unit of measurement;          MDS (Minimum Data Set) - standardized.</p>	F 000	<p>Churchman Village has received the statement of deficiencies for the annual survey completed on February 29, 2016. Below is a Plan of Correction to address those alleged deficiencies. The Center provides this Plan of Correction without admitting to or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. We request that you consider the Plan of Correction as the Center's allegation of substantial compliance as of May 6, 2016.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DEAN C. REID TITLE: EXEC. DIR (X6) DATE: 3/30/16

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 assessment used in nursing homes; MOM (Milk of Magnesia) - medication to promote bowel movement; POS - Physician Order Sheet; PRN - As needed; Pre-before; Post- after; TAR - Treatment Administration Record (on paper); Acetaminophen (Tylenol) - medication for pain or fever; Always Incontinent - no episodes of continence; Antianxiety - drug used to treat nervousness, restlessness or feelings of worry; Antipsychotic- drug used to treat mental and emotional conditions; Anxiety - nervousness, restlessness or feelings of worry; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15: (13-15= Cognitively intact; 8-12=Moderately impaired; 0-7= Severe impairment); Blue Boot(ies) - quilted heel protectors to relieve pressure; Buttocks-either of two round fleshy parts that form the lower rear area of the human trunk; Cognition - mental processes or thinking; Constipation - difficulty in passing stool; Continence - control of bladder and/or bowel function; Eplthelialization - new skin cells that are a different color [usually white or plnk] from surrounding area; Eschar - hard dead tissue that can be tan, brown or black; Extensive Assistance - resident involved in activity; staff provide weight-bearing support; Femur - thigh bone;	F 000		
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F 000	<p>Continued From page 2</p> <p>Float heels - raise heels to remove pressure (i.e., lifting on pillow), see offloading;</p> <p>Frequently Incontinent - 7 or more episodes of urinary incontinence per week with at least 1 episode of continent urinary voiding;</p> <p>Granulation - new tissue with blood vessels formed during wound healing;</p> <p>Hoyer lift - sling-type mechanical lift;</p> <p>Hydrogel - gel treatment to provide moisture for wound healing;</p> <p>i.e.-that is;</p> <p>Incontinence - loss of control of bladder and/or bowel function;</p> <p>Limited Assistance - resident highly involved in activity; staff provide non-weight bearing assistance;</p> <p>Mobility - motion of getting around;</p> <p>Occasionally Incontinent - less than 7 episodes of urinary incontinence per week;</p> <p>Offloading - removal of pressure from an area;</p> <p>Oxycodone - pain medication;</p> <p>Pain Rating Scale - number scale (0 to 10) to rate pain where 0 is no pain and 10 is the worst pain possible;</p> <p>PU-Pressure Ulcer- Staging (severity)</p> <ul style="list-style-type: none"> <li>- Stage I (1) - Intact red skin often over a boney area that does not turn white/light when pressed;</li> <li>- Stage II (2) - blister or shallow open sore with red/pink color;</li> <li>- Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin;</li> <li>- Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt;</li> <li>- Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough;</li> </ul>	F 000		
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F 000	Continued From page 3 - Suspected Deep Tissue Injury (sDTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue; Roxanol - liquid pain medication; Santyl - ointment containing enzyme that helps remove dead tissue/slough; Selzure disorder - abnormal electrical activity in the brain causing repetitive muscle jerking; Slough - yellow, tan, gray, green or brown dead tissue; TIA - Transient Ischemic Attack- mini stroke; Toileting program - fixed time interval of toileting assistance for resident with urinary incontinence; Total Dependence - full staff performance every time; UTI - urinary tract infection-bacteria in the urine; Voiding diary - log completed every hour for three days of how much the resident voided and the number of incontinent episodes; X-ray - picture taken of bones or organs.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157	F157 1. The responsible party for R61 was notified on the change in condition per policy. 2. All residents have the potential to be affected by this deficient practice. 3. (A) The Director of Nursing (DON) and Regional clinical nurse reviewed the facility's Notification of Changes policy and determined it is adequate. (B) The staff developer will educate licensed staff on the facility's Notification of Changes policy and timely family/legal representative notification. 4. (A) New practice: during morning meetings the DON and the IDT will review any residents that have had a change in condition and will monitor if the staff followed the facility's policy. (B) The DON/designee will conduct weekly audits on the timeliness of notification. The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.	05/06/2016	

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F 157	<p>Continued From page 4</p> <p>consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R61) out of 32 sampled residents the facility failed to promptly notify the responsible party of a resident's change of condition. Findings include:</p> <p>The facility's Policy: Notification of Changes dated 9/10/13 indicated notification of: a significant change, a need to alter treatment significantly, decision to transfer, and an accident that resulted in injury and has the potential for requiring physician interventions.</p> <p>The following was reviewed in R61's clinical record:</p> <p>2/16/16 (12:30 PM) - A nurse's note documented that the patient was unresponsive at lunch time</p>	F 157			

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F 157	Continued From page 5 and was returned to room.  2/16/16 (untimed) - Physician progress note documented the resident had unresponsive episode and noted possible TIA or seizure.  An interview on 2/25/16 at 2:01 PM with E6 (RN,UM) revealed that E6 understood the responsible party was notified later on the same day by the 3-11 supervisor. E6 stated he spoke with the family member the next day (2/17/16) who was aware of the episode at that time.  An interview on 2/26/16 at 11:30 AM with E16 (LPN) revealed that E16 spoke to the NP at 3:00 PM the day before when she came into the facility and the NP wrote new orders. E16 further stated that she did not notify the family but she did hear the 3:00 PM - 11:00 PM supervisor on the phone speaking to the family.  The facility failed to promptly notify the responsible party of a resident's change of condition.  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 PM.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:	F 241	F241  1. Once the surveyor informed the facility of the deficient practice E7 was educated on the use of correct terminology. 2. All residents that need to be fed have the potential to be affected by this deficient practice. 3. (A) The Staff Developer will educate licensed and non-licensed staff on the correct terminology for residents that need to be fed, terminology that promotes dignity. (B) The Staff Educator will develop and implement a course on the use of appropriate terminology when referring to residents that need assistance. The course will be included in New Hire Orientation (NHO) and Annual Mandatory Education (AMR). 4. (A) The Food Service Director/designee will make weekly meal rounds in all dining areas to monitor that appropriate terminology is being used. (B) The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.	05/06/2016	

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F 241	Continued From page 6 Based on observation it was determined that the facility failed to maintain residents' dignity when facility staff addressed residents requiring to be fed using the label of "feeders". Findings include:  On 2/18/16 at 11:46 AM during lunch service on the East wing, the surveyor stood 8-10 feet away from the meal cart in the hallway. E7 (CNA) was next to the meal cart and asked four nursing assistant students wearing maroon uniforms and their instructor "How many feeders do you have?".  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 PM.	F 241			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide reasonable accommodation of needs for 1 (R38) out of 32 sampled residents. R38's distressful verbalizations were not addressed when a CNA was in the room and R38's call bell was found on the floor out of the resident's reach. Findings include	F 246	F246 1. Once the surveyor informed the facility of the deficient practice E18 was educated on addressing the needs of the residents regardless of the job task being performing. Additionally E18 was educated on the need to observe if residents' call bells are within reach every time they enter a resident's room. 2. All residents have the potential to be affected by this deficient practice. 3. The Staff Educator will develop and implement a course that teach the staff to addresses resident's regardless of the task they are performing. Staff will be educated on observing if the call bell is within reach every time they enter a room. The course will be included in New Hire Orientation	05/06/2016	

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F 246	<p>Continued From page 7</p> <p>R38's current February, 2016 care plan for "demanding immediate attention" included approaches to listen to resident and try to calm, remind when you will return and assess/manage unmet needs.</p> <p>An observation on 2/25/16 at 2:55 PM revealed that R38 was making loud continual verbalizations such as "uh uh". At the same time E18 (CNA) came out of the room and left the unit without seeming to notice or react to R38's sounds. Observation in the room revealed R38 was making distressful verbalizations and the resident's call bell was on the floor out of the resident's reach. E15 (CNA) was then observed making change of shift rounds to check call bells on the unit. E15 entered R38's room, checked the call bell and returned it to the resident. E15 also requested that E19 (LPN) check R38 for pain. E19 was observed entering the resident's room at 3:06 PM.</p> <p>An interview on 2/25/16 at 3:15 PM with E18 revealed that when she was in R38's room she did not notice the resident was making continual distressful sounds or that the call bell was on the floor. E18 further stated that she was focused on going from room to room to deliver supplies for the evening shift.</p> <p>An interview on 2/25/16 at 3:18 PM with E19 revealed that R38 denied being in pain but had wanted to get out of bed.</p> <p>Review of a nurse's note dated 2/25/16 and timed 4:20 PM by E19 documented: "Resident alert to self with confusion. Staff anticipates needs when resident is unable to make them known. CNA called the nurse to the resident's room to assess</p>	F 246	<p>F246 (cont.)</p> <p>3. (cont) (NHO) and Annual Mandatory Education (AMR).</p> <p>4. The DON/designee will make weekly rounds on all units to monitor if staff are addressing the needs of the residents, including call bells being within reach. The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.</p>		

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F 246	Continued From page 8 for pain because resident was groaning and fidgeting with the beddings. This is not unusual for the resident. When asked if she was in pain, resident expressed that she was not in any pain. She was asked if she wanted to get out of bed to her chair, she said she would later with some help. Resident was pulling the bed sheet over across the other bedding and pushing the bed control and the call light away from her. Resident was assisted to get out of bed to the wheelchair via hooyer lift. Resident was calm after getting out of bed and participated in mall delivery to other residents with activlities director."	F 246			
F 252 SS=E	On 2/29/16 at 8:15 AM, this incident was reviewed with E3 (ADON).  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 PM. 483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b>  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, It was determined that the facillty failed to provide a home like environment during dining by leaving served meals on trays in the assisted dining room. Findings include:  Random dining observations revealed the	F 252	F252 1. The facility is unable to retroactively address the meal observations made by the surveyors on 2/18/16. 2. All residents that eat in the assisted dining room have the potential to be affected by this deficient practice. 3. (1) It is now the policy of the facility to remove the dishes from the meal tray when serving residents. (2) Licensed and non-licensed staff will be required to take the Relias Course "Meal Trays in the Dining Room". 4. The Food Service Director/designee will make weekly rounds in all dining rooms to monitor that dishes are being removed from the meal tray. The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.	05/06/2016	

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F 252	Continued From page 9 following:  On 2/18/16 during lunch observation, 11 out of 11 residents in the assisted dining room received their meal on a tray and the dishes remained on the tray during the entire meal.  During an interview on 2/18/16 at 12:16 PM, E15 (CNA) was asked if residents were usually served their meals on trays in the assisted dining room and E15 replied yes always.  On 2/19/16, 2/22/16 and 2/23/16 during lunch observations of 11 out of 11 residents in the assisted dining room received their meal on a tray and the dishes remained on the tray during the entire meal.  These findings were reviewed with E1 (NHA) and E2 (DON) at 2:40 PM.	F 252		
F 272 SS=D	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;	F 272	F272 1. Section H on R131 and R1's MDS's are now coded correctly. 2. (A) All residents have the potential to be affected by this deficient practice. (b) All admission MDS that have been completed within the past 90 days on active residents will have Section H audited for accuracy. Corrections will be made accordingly. 3. (A) The MDS coordinator will complete the Relias training "MDS 3.0 Section H Bladder and Bowel". (B) Now on a monthly basis the DON/designee will audit 20% of Section H on all MDSs to monitor for accuracy. Corrections will be made accordingly.	05/06/2016

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>		
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F 272	Continued From page 10 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.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R131 and R1) out of 32 sampled residents the facility failed to ensure the accuracy of the comprehensive assessment. Findings include:  1. Cross refer F315.  The following was reviewed in R131's clinical record:  10/24/15 - 10/26/15 - Bowel and Bladder Evaluation documented all opportunities as continent except three episodes of being wet.	F 272	F272 (cont) 4. The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.		

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F 272	Continued From page 11  10/30/15 - Admisslon MDS Incorrectly documented that R131 was continent of urine instead of occasionally incontinent of urine.  October, 2015 - ADL Flow Record incorrectly documented that the resident was always continent even though there were three episodes of Incontinence on the bowel and bladder evaluation.  An interview on 2/29/16 at 9:52 AM with E4 (RNAC) confirmed that based on the ADL Flow Record the 10/30/15 MDS assessment was not coded correctly.  2. R1's admission MDS was incorrectly coded for urinary incontinence:  10/22/15 - 10/31/15 ADL Flow Record documented that R1 was always incontinent on every shift, sometimes 2-3 times a shift. There were no episodes of continence for this resident.  10/29/15- Admisslon MDS Assessment incorrectly documented that R1 was frequently incontinent of urine Instead of always incontinent of urine.  During an interview on 2/29/16 at approximately 10:30 AM, E2 (DON) confirmed that based on the ADL Flow Record the 10/29/15 Admission MDS assessment was not coded correctly.  These findings were reviewed with E1 (NHA) and E2 on 2/29/16 at 2:40 PM.	F 272			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		05/06/2016	

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F 278	Continued From page 12  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 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.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R22 and R99) out of 32 sampled residents the facility failed to ensure the accuracy of the assessment. Findings include:  1. The following was reviewed in R22's clinical record:	F 278	F278 1. Section G on the MDS's for R22 and R99's are now coded correctly. 2. (A) All residents have the potential to be affected by this deficient practice. (B) All MDS's that have been completed within the past 90 days on active residents will have Section G audited for accuracy. Corrections will be made accordingly. 3.(A) Certified nursing assistance will complete the Relias Training "Documenting Activities of Daily Living". (B) The MDS coordinator will complete Relias Training "MDS Section G". (C) Now on a monthly basis the DON/ designee will audit 20% of Section G on all MDS completed for accuracy. Corrections will be made accordingly. 4. The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.	05/06/2016	

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F 278	Continued From page 13  4/2/15 - Annual MDS Assessment documented that R22 needed extensive assistance with toilet use.  October 2015 and November 2015 - ADL Flow Record documented the resident needed extensive assistance with toileting on night shift and was dependent on staff for day and evening shifts.  December, 2015 - ADL Flow Record documented the resident was dependent on staff all three shifts with toileting.  12/31/15 - Quarterly MDS Assessment documented that R22 was dependent on staff for toilet use.  January, 2016 - ADL Flow Record documented the resident was dependent on staff day and evening shift and needed extensive assistance at night with toilet use.  An interview on 2/23/16 at 2:59 PM with E14 (CNA) revealed that R22 had been using a disposable undergarment and has been dependent on staff changing for over a year now.  An interview on 2/29/16 at 10:30 AM with E4 (RNAC) confirmed a resident dependent on staff for a disposable undergarment change should be coded as dependent for toilet use on the MDS assessment.  Staff were at times Incorrectly coding R22's toilet use as extensive assistance when this resident was actually dependent on staff to change her when she was incontinent.	F 278			

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F 278	Continued From page 14  2. Review of R99's clinical record revealed; 9/10/15 - Quarterly MDS assessment rated the R99's performance for toilet use as needing limited assistance.  2/21/16 review of the September, 2015 ADL Flow Record - found that, during the 7-day look back period used for the quarterly MDS assessment, R99 was rated as needing limited assistance daily on both day and night shifts and was rated as totally dependent daily on the evening shift.  During an interview on 2/22/16 at 10:00 AM, the surveyor asked E4 to rate the resident's toilet use using the ADL Flow Record information from the 7-day look back period. E4 stated the rating should be rated as extensive assistance and confirmed that the limited rating was not correct on the quarterly MDS assessment.  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 AM.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are	F 279	F279 1. R22 and R64's dental care plans have been corrected. 2. (A) All residents have the potential to be affected by this deficient practice. (B) All residents will have their dental care plans audited for accuracy. Corrections will be made accordingly. 3. (A) Licensed staff will complete the Relias training "Care Planning in LTC". (B) Now the MDS coordinator/designee will audit 20% of Section L against the resident's dental care plans for accuracy	05/06/2016	

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F 279	<p>Continued From page 15</p> <p>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: Based on record review and interview it was determined that for two (R22 and R64) out of 32 sampled residents the facility failed to develop an appropriate care plan based on the comprehensive assessment. Findings include:</p> <p>1. The following was reviewed in R22's clinical record:</p> <p>4/2/15 - Annual MDS documented no natural teeth or tooth fragments (edentulous).</p> <p>9/21/15 - Care plan for dental care that documented resident exhibits or is at risk for oral health or dental care problems as evidenced by broken loose and carious teeth.</p> <p>An interview on 2/23/16 at 2:41 PM with R22 revealed that she had upper and lower dentures. She went on to say that the bottom dentures were a partial plate and she had two natural teeth on the bottom. The resident denied any problems with her teeth or dentures.</p> <p>An interview on 2/23/16 at 2:58 PM with E14 (CNA) revealed that the resident had a full set of dentures on top and a partial on the bottom with a</p>	F 279	<p>F279 (cont)</p> <p>3. (B) (cont.) before submitting . Corrections will be made accordingly.</p> <p>4. The results of these audits will be reviewed in the monthly QAPI until 100% compliance is achieved.</p>		

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F 279	Continued From page 16 couple of natural teeth.  An interview on 2/29/16 at 11:13 AM with E5 (RN, UM) confirmed that the care plan problem was not appropriate for this resident who did not have broken, loose or carious teeth.  2. The following was reviewed in R64's clinical record:  6/5/15 - Admission MDS Assessment documented no dental problems.  8/25/15 - Care plan for dental care documented that resident exhibits or is at risk for oral health or dental care problems as evidenced by broken, loose or carious teeth.  An interview on 2/23/16 at 1:50 PM with R64 revealed that the resident had all his natural teeth and had no dental problems.  An interview on 2/29/16 at 11:14: AM with E6 (RN, UM) confirmed that the care plan problem was not appropriate for this resident who did not have broken, loose or carious teeth.  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 PM.	F 279			
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.	F 309	F309 1. (A) R38's record now has a physician's order which indicates that Tylenol may be administered for both pain and/or fever. Licensed nurses are now documenting on the date, time, drug, reason for administration of the PRN pain medication. Licensed nurses are also assessing R38's	05/06/2016	

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F 309	Continued From page 17  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to 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 for 4 (R38, R87, R75 and R112) out of 32 sampled residents. The facility failed to assess the need for, and resident response to, PRN pain medications and failed to assess pain using the same numeric score before and after PRN pain medication for the four residents. For R38 the facility also failed to monitor and assess for constipation. Findings include:  According to Lippincott's Nursing 2014 Drug Handbook, the 8 rights of medication administration were as follows: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, and 8. Right response. (Reference: Nursing 2014 Drug Handbook. (2014). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.)  The facility recorded PRN medications on a monthly paper PRN MAR. On the front of the form where each PRN medication was listed, the ordered frequency and the ordered reason were also listed, the nurse would write the time given along with his/her initials under the specific date for each administration. On the back of the form the nurse would write the date/hour, medication, reason for administration and the result (resident	F 309	F309 (cont.) 1. (A) (cont.) pain before and after administering PRN pain medication in a numeric format on the back of the PRN MAR. (B) R38 is now being administered bowel protocol per the facility's policy. (C) R87, R77, R112 are now receiving pain medication per facility's policy. Licensed nurses are documenting the date, time, drug, reason for administering PRN medication. Licensed nurses are also assessing the resident's pain before and after in a numeric format on the back of the PRN MAR. 2. (A) All residents have the potential to be affected by this deficient practice. (B) All residents will have their Certified Nursing Assistant flow sheets audited for the past seven days to monitor that the facility's bowel protocol, PRN documentation of date, time, drug, reason for administration, and assessing pain scale before and after administration has been implemented. Corrections will be made accordingly. 3. (A) The Staff Developer will educate licensed staff on the facility bowel protocol. (B) The Staff Developer will educate licensed staff on the need to document the date, time, drug, reason for administering PRN pain medication. Educations will include the need to assess the resident's		

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F 309	<p>Continued From page 18 response) in the designated area for each PRN medication given.</p> <p>Pain management standards, approved by the American Geriatrics Society in April 2002, included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.</p> <p>1. Review of R38's clinical record revealed: A. 10/25/15 - X-ray report showed a broken left knee/femur (bottom end of thigh bone).</p> <p>November, 2015 POS - included PRN medication in addition to two scheduled pain patches and Tylenol to be given at 9:00 AM, 1:00 PM and 5:00 PM: - 11/24/13 Tylenol to be given every 6 hours PRN for increased temperature.</p> <p>November, 2015 - Pain Level Monitoring Record form indicated the numeric pain scale was being used for R38.</p> <p>November, 2015 PRN MAR - showed R38 received PRN Tylenol thirteen (13) times. - Eleven (11) administrations (84.6%) lacked documentation on the back of the PRN MAR with no evidence as to the reason for the administration, nor resident response to the medication. Since the ordered indication was for increased temperature, review of temperatures found only one instance (11/20/15 at 9:55 PM) when R38 had an elevated temperature (99.4 F)</p>	F 309	<p>F309 (cont.)</p> <p>3. (B) (cont.) pain before and after administration in a numeric format (or Wong Baker pain scale when appropriate) on the back of the PRN MAR. (C) Prior to the morning meeting the Unit Managers will review all residents flow sheets to monitor that the bowel protocol was administered appropriately. The Unit Manager will report the results of this audit in morning meeting. (D) At the end of each shift the supervisor/designee will check the PRN MAR's to monitor that pain medications was administered and documented to protocol.</p> <p>4. (A) Weekly the DON/designee will audit 20% of active resident's Certified Nursing Assistant flow sheets to monitor that the BM protocol was initiated and followed per protocol. (B) Weekly the DON/designee will audit 20% of PRN MAR's to monitor that medications were given per protocol. (C) The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.</p>	

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F 309	<p>Continued From page 19</p> <p>on dates when Tylenol was given.</p> <p>- Two (11/1/15 at 6:30 AM and 11/12/15 at 7:00 PM) administrations with information recorded on the back of the PRN MAR indicated the reason was pain even though the POS stated the medication was to be given for increased temperature. One of these two entries lacked the resident's numeric pain rating before and after administration.</p> <p>December, 2015 POS - included both reasons (pain and elevated temperature) for the PRN Tylenol.</p> <p>December, 2015 PRN MAR - showed the resident received PRN Tylenol two (2) times and there was no documentation on the back of the form for either administration with no evidence as to the reason for these administrations, nor resident response to the medication.</p> <p>During a 2/25/16 interview at 10:00 AM with E5 (RN, UM), E5 confirmed the missing reason and resident response for the numerous Tylenol administrations. E5 acknowledged the November, 2015 POS only had increased temperature as the reason for the PRN Tylenol and that there was inconsistent assessment using the same numeric score before and after pain medication.</p> <p>On 2/25/16 around 11:10 AM, E8 (LPN) stated that when a PRN medication is given, the nurse should record the date, time, drug, reason and resident response on the back of the PRN MAR.</p> <p>B. Review of physician orders found the standard bowel protocol in the facility included: - Step 1: MOM if no BM in 9 shifts.</p>	F 309		

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F 309	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>- Step 2: Suppository if no BM in 10 shifts as needed for constipation.</li> <li>- Step 3: Enema if no BM in 11 shifts.</li> </ul> <p>R38's October, 2015 POS included a daily oral medication for constipation and no PRN medications for constipation, no bowel protocol was ordered for this resident.</p> <p>October and November, 2015 ADL Flow Records and ADL Correction Forms - review of these documents revealed R38 did not have a BM for 9 shifts:</p> <p>a. October: five (5) separate occasions ranging from 10-15 shifts.</p> <ul style="list-style-type: none"> <li>- 10 shifts October 1 (nights) - 4 (nights) with no evidence of intervention in the record.</li> <li>- 15 shifts October 4 (evenings) - 9 (evenings): after 15 shifts an order for a one-time suppository was obtained and administered on 10/9/15, resulting in a large BM.</li> <li>- 15 shifts October 16 (evenings) - 21 (days) with no evidence of intervention.</li> <li>- 10 shifts October 22 (nights) - 25 (nights) with no evidence of intervention.</li> <li>- 12 shifts October 25 (evenings) - 29 (days): after 10 shifts an order for a one-time oral medication was obtained and administered with no effect. After 11 shifts a one-time order for a suppository was obtained, administered and resulted in a large BM.</li> </ul> <p>b. November: four (4) separate occasions ranging from 10-22 shifts.</p> <ul style="list-style-type: none"> <li>- 13 shifts November 1 (evenings) - 5 (evenings) with no evidence of intervention in the record.</li> <li>- 12 shifts November 11 (evenings) - 15 (days): after 12 shifts an order for the bowel protocol was obtained on 11/15/15, a suppository produced</li> </ul>	F 309			

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NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>		
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F 309	<p>Continued From page 21 only a small BM.</p> <ul style="list-style-type: none"> <li>- 10 shifts (the 11/18/15 night shift entry was missing and was counted as no BM) November 16 (nights) - 19 (nights) with no evidence the bowel protocol was implemented after the 9th shift on 11/8/15 evening.</li> <li>- 22 shifts November 22 (evenings) - 29 (evenings) with no evidence the bowel protocol was implemented after the 9th shift on 11/25/15 evening or any of the subsequent eleven (11) shifts. After 21 shifts, on 11/29/15 at 2:00 PM, an attempt to complete Step 1 of the bowel protocol was recorded but the resident refused. The back of the PRN MAR contained a note indicating the resident also refused to return to bed after lunch for an enema (step 3). There was no evidence in the record that the suppository (step 2) of the protocol was ever attempted.</li> </ul> <p>During a 2/25/16 interview at 10:10 AM with E5 (RN, UM) the surveyor reviewed the ADL Flow Records showing shifts with no BMs. E5 stated additional BM information may be on the ADL Correction Form if the resident had a BM after the documentation was completed for that shift. [Surveyor later found no additional BM documentation on these correction forms].</p> <p>For R38 the facility failed to:</p> <ul style="list-style-type: none"> <li>- administer PRN Tylenol for the ordered indication.</li> <li>- record the reason for administration and resident response after treatment for 87% of PRN Tylenol doses in October and November 2015.</li> <li>- failed to consistently assess the resident's pain using the same numeric score before and after PRN pain medication; and</li> <li>- treat constipation on seven (7) occasions when the resident did not have a bowel movement for</li> </ul>	F 309			

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F 309	<p>Continued From page 22 over nine (9) shifts, ranged from 10 - 22 shifts.</p> <p>2. Review of R87's clinical record revealed: November, 2015 POS - included the following PRN pain medications: - Tylenol every 4 hours for mild pain/fever - Oxycodone 2.5 mg every 6 hours for moderate pain - Oxycodone 5 mg every 6 hours for severe pain - Roxanol every 2 hours for shortness of breath/pain/restlessness/respiratory distress</p> <p>November, 2015 - Pain Level Monitoring Record form indicated the numeric pain scale was being used for R87.</p> <p>November, 2015 PRN MAR and nursing notes review found: a. Tylenol: three (3) of the four (4) administrations (75%) lacked documentation on the back of the PRN MAR with no evidence as to the reason for these administrations nor resident response to the medication. - 11/4/15 at 5:30 PM entry on the back of the MAR lacked the post-medication numeric pain assessment. - Nursing note 11/5/15 at 7:45 AM stated the resident received Tylenol for complaints of generalized pain, but the numeric pain rating assessment before and after the medication was not assessed. It was not clear why this information was written in a nursing note and not on the back of the MAR.</p> <p>b. Oxycodone 2.5 mg: five (5) of the six (6) administrations (83%) lacked documentation on the back of the PRN MAR with no evidence as to the reason for these administrations, nor resident response to the medication.</p>	F 309			

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F 309	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>- 11/9/15 at 8:20 AM entry on the back of the MAR recorded the incorrect dose: 5 mg was written when 2.5 mg was given for a pain level of 4 (four).</li> <li>- Nursing notes 11/5/15 at 10:30 PM and 11/7/15 at 9:42 PM stated the medication was given for complaint of pain and was effective but location of the pain and numeric pain rating assessment was not included. It was not clear why this information was written in a nursing note and not on the back of the MAR.</li> <li>c. Oxycodone 5 mg: three (3) of the six (6) administrations (50%) lacked documentation on the back of the PRN MAR with no evidence as to the reason for these administrations, nor resident response to the medication. <ul style="list-style-type: none"> <li>- The three (3) entries that were on the back of the MAR were not complete: 11/7/15 at 9:00 AM lacked post treatment numeric pain rating and 10 mg dose was written when 5 mg was given; 11/8/15 at 6:30 AM lacked post treatment numeric pain rating; and 11/11/15 at 4:00 PM lacked both the pre and post treatment numeric pain rating.</li> <li>- Nursing note 11/9/15 at 10:43 PM stated the resident was medicated (no name of the drug /dose of drug) at bedtime for generalized pain with a 5/10 pain rating with relief, but lacked the numeric pain rating assessment after treatment. It was not clear why this information was written in a nursing note and not on the back of the MAR.</li> </ul> </li> <li>d. Roxanol: twenty five (25) of the twenty nine (29) administrations (86%) lacked documentation on the back of the PRN MAR with no evidence as</li> </ul>	F 309			

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F 309	<p>Continued From page 24</p> <p>to the reason for these administrations nor resident response to the medication.</p> <ul style="list-style-type: none"> <li>- Four (4) entries that were documented on the back of the MAR were not complete: 11/15/15 at 1:00 AM, 9:30 AM, 12:30 PM and 2:30 PM were missing resident response.</li> <li>- Nursing note 11/12/15 at 11:05 PM stated the resident was medicated at 8:00 PM for restlessness, with effectiveness. It was not clear why this information was written in a nursing note and not on the back of the MAR.</li> <li>- Nursing note 11/13/15 at 7:43 AM stated R87 was medicated at 12:00 AM, 3:00 AM and 7:00 AM with good result. There was no indication as to the reason for these administrations. The nurse wrote comfort care maintained. It was not clear why this information was written in a nursing note and not on the back of the MAR.</li> <li>- Six (6) more nursing notes between 11/13/15 through 11/15/15 documented the medication was given but the notes lacked the administration times, reason for administration and/or resident response. It was not clear why this information was written in a nursing note and not on the back of the MAR.</li> </ul> <p>On 2/29/16 around 10:30 AM, the surveyor reviewed the PRN MARs containing missing information with E2 (DON).</p> <p>For R87 the facility failed to:</p> <ul style="list-style-type: none"> <li>- record the administration reason and resident response for 36 out of 45 doses (80%) of PRN pain medication on the back of the PRN MAR.</li> <li>- failed to consistently assess resident's pain using the same numeric score before and after PRN pain medication.</li> </ul>	F 309		

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F 309	<p>Continued From page 25</p> <p>3. Review of R77's clinical record revealed:</p> <p>The February, 2016 Pain Level Monitoring Form indicated a numeric scale was being used for R77.</p> <p>On 2/7/16, R77 was medicated at 10:00 AM with PRN pain medication. There was no documentation detailing where the pain was located. There was no evidence the pain was assessed before and after medication administration using the numeric scale.</p> <p>On 2/21/16, R77 was medicated at 9:00 AM with PRN pain medication. There was no documentation detailing where the pain was located. There was no evidence the pain was assessed before and after medication administration using the numeric scale.</p> <p>Interview on 2/29/16 at 9:45 AM with E11 (Charge Nurse) confirmed that there was no documentation detailing the pain level for R77.</p> <p>4. Review of R112's clinical record revealed:</p> <p>The February, 2016 Pain Level Monitoring Form indicated a numeric scale was being used for R112.</p> <p>On 2/14/16, R112 was medicated at 9:00 AM with PRN pain medication. There was no documentation detailing where the pain was located. There was no evidence the pain was assessed before and after medication administration using the numeric scale.</p> <p>On 2/20/16, R112 was medicated at 9:00 PM with PRN pain medication. There was no</p>	F 309			

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F 309	Continued From page 26 documentation detailing where the pain was located. There was no evidence the pain was assessed before and after medication administration using the numeric scale.  Interview on 2/29/16 at 9:45 AM with E11 (Charge Nurse) confirmed that there was no documentation detailing the pain level for R112.  These findings were reviewed with E1 (NHA) and E2 at 2:40 PM.	F 309			
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 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for 2 (R22 and R145) out of 32 sampled residents the facility failed to provide residents with an existing pressure ulcer, care and services to promote healing and prevent new sores from developing. Findings include:  1. Observation and record review revealed the following for R22:	F 314		05/06/2016	

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F 314	<p>Continued From page 27</p> <p>7/30/15 - A physician's order stated to off load heels when in bed. This order remained on the 2/2016 POS.</p> <p>9/21/15 - A care plan problem was created for being at risk for skin breakdown as evidenced by limited mobility and incontinence. Approaches included to float heels in bed.</p> <p>October, 2015 - Resident Flow Record included the approach for blue boots to bilateral heels while in bed. Blue (quilted) boots provide pressure reduction but does not relieve or off-load the heel pressure. Staff only documented using the boots once this month.</p> <p>November, 2015 - Resident Flow Record documented use of blue boots 40 out of 90 shifts.</p> <p>December, 2015 - Resident Flow Record documented use of blue boots 22 out of 93 shifts.</p> <p>12/31/15 - Quarterly MDS Assessment documented R22 had a BIMS score of 15 indicating the resident was cognitively intact, required extensive assistance with bed mobility and was dependent on staff for transfers.</p> <p>January, 2016 - Resident Flow Record documented use of the blue boots 25 out of 93 shifts.</p> <p>1/18/16 - A care plan problem was created for actual skin breakdown related to a pressure wound. Approaches included a weekly assessment by a licensed nurse.</p> <p>1/18/16- Pressure Wound Documentation form documented a stage I PU to left buttock. The</p>	F 314	<p>F314</p> <p>1. (A) The correct tissue for R22's and R145's wounds are now documented. (B) R22's and R145's heels are now being off loaded with heels-elevated cushion. (C) R145's flow record now indicates that both heels are to be offloaded.</p> <p>2. (A) All residents with wounds have the potential to be affected by this deficient practice. (B) All residents' wound documentation will be audited to monitor that the correct tissue type is documented. Corrections will be made accordingly. (C) Offloading for heels will be done with heels-elevating cushions versus blue boots. Physician's orders and care plans will be changed to read "offload heels with heels-elevating cushion as resident tolerates"</p> <p>3. (A) The facility will educate wound nurse/staff on relias training "About wound care: identification and assessment". The wound nurse and unit nurse manager/ designee will conduct weekly wound rounds for documentation accuracy. (B) The facility will change their protocol to off load heels with heels elevating cushion. (C) The Staff Developer will educate certified nursing aides and licensed nursing to off load heels with heels elevating cushion.</p> <p>4. (A) The DON/designee will make weekly rounds to monitor that residents heels are being offloaded with heels elevating cushion.</p>	05/06/2016

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F 314	<p>Continued From page 28</p> <p>assessment incorrectly document 100% granulation tissue instead of epithelial tissue.</p> <p>1/27/16 and 2/1/16 - Pressure Wound Documentation forms documented a stage I PU and incorrectly identified epithelial tissue as granulation tissue.</p> <p>2/3/16 - a physician's order for a treatment change to Hydrogel was obtained. There was no corresponding assessment of the wound. The treatment change would indicate that the wound was open and no longer a stage I PU.</p> <p>2/8/16 - Pressure Wound Documentation form documented as stage II PU with 25% granulation tissue and 75% slough tissue. The presence of slough indicated the PU was actually a stage III or greater. The wound was incorrectly assessed.</p> <p>2/8/16 - a physician's order was obtained to change the treatment to Santyl to help remove slough.</p> <p>2/15/16 - Pressure Wound Documentation form documented a stage III PU with 100% slough. The PU should have been assessed as unstageable since the presence of 100% slough prevented the depth from being determined.</p> <p>2/22/16 at 2:02 PM and 3:06 PM - R22 was observed in bed with no off loading of the heels.</p> <p>2/23/16 at 9:20 AM - R22 was observed in bed with no off loading of the heels.</p> <p>An interview on 2/23/16 at 9:51 AM with E5 (RN, UM) revealed that when the PU treatment was changed to Hydrogel it was because the wound</p>	F 314	<p>F314 (cont.)</p> <p>4. (cont.)</p> <p>(B) The wound consultant will provide weekly reports to the facility which include documentation on tissue type.</p> <p>(C) The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.</p>		

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F 314	<p>Continued From page 29</p> <p>had become darker and opened. E5 stated the treatment was changed to Santyl when the slough appeared.</p> <p>2/23/16 1:42 PM, 2:15 PM and 2:39 PM - R22 was observed in bed with no off loading of the heels.</p> <p>2/25/16 1:55 AM - R22 was observed in bed with no off loading of the heels.</p> <p>An interview on 2/29/16 at 10:30 AM with E2 (DON) confirmed the heel wound was not reassessed as a stage II when the Hydrogel was ordered, that improper tissue types were documented on the PU assessments and that blue boots do not off load pressure from the heels.</p> <p>2. R145 was a newly admitted resident (1/14/16) who came from the hospital with a sDTI to the left heel. The following was observed and reviewed in the clinical record;</p> <p>1/14/16 - Physician's order to off load left heel at all times with a blue boot. The blue boot reduces pressure but does not relieve pressure like off loading does. The facility incorrectly used a blue boot for off loading.</p> <p>1/14/16 - A care plan problem for resident at risk for skin breakdown included an approach to float heels while in bed.</p> <p>1/14/16 - A care plan problem for actual skin breakdown included an approach to use blue boot to left heel when in bed.</p> <p>1/14/16 - Pressure Wound Documentation form</p>	F 314		

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F 314	<p>Continued From page 30</p> <p>documented a left heel sDTI. The form incorrectly assessed the tissue type as granulation instead of epithelial.</p> <p>1/15/16 - A care plan problem for a pressure ulcer for a resident that is at risk for skin breakdown included an approach to float heels when in bed.</p> <p>1/18/16 - Pressure Wound Documentation form documented a left heel sDTI. The form incorrectly assessed the tissue type as granulation instead of epithelial.</p> <p>1/19/16 - Geriatric Medicine Consultants/Admission/Annual History and Physical lacked assessment of a left heel PU.</p> <p>1/21/16 - Admission MDS documented the resident required extensive assistance with bed mobility and had a sDTI on admission.</p> <p>1/26/16, 2/1/16, 2/8/16, 2/15/16, 2/22/16 - Pressure Wound Documentation forms documented a left heel sDTI. The forms also assessed the tissue type as eschar. The facility failed to classify the wound as unstageable due to the presence of eschar.</p> <p>1/26/16, 2/8/16, 2/18/16 - Geriatric Medicine Consultants/Progress Notes lacked assessment of a left heel PU.</p> <p>January, 2016 - Resident Flow Record documented approaches to off load heels in bed and to use a blue boot on left heel when in bed.</p> <p>February, 2016 - Resident Flow Record documented only the blue boot to left heel. There was no entry to offload heels.</p>	F 314		

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F 314	Continued From page 31  2/23/16 9:25 AM - R145 was observed in bed lying on back with socks on feet which were laying directly on mattress. The heels were not offloaded.  2/23/16 10:57 AM - R145 was observed in bed with a blue boot on left heel and right foot in a sock laying directly on the bed. Neither heel was off loaded. The treatment observation was conducted and R145's feet were not off loaded after the treatment.  2/23/16 1:46 PM - R145 was observed in bed on back no off loading noted.  2/25/16 1:55 PM - R145 was observed in bed on back. No off loading was noted  2/26/16 2:57 PM - R145 was observed in bed without off loading. The blue boot was laying on the heater unit and was not on the resident.  These findings were reviewed with E1 (NHA) and E2 on 2/29/16 at 2:40 PM.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315  1. R131's MDS is now coded as occasionally incontinent. A new toileting plan has been initiated for R131 and the staff is documenting the effectiveness of the plan. 2. (A) All residents have the potential to be affected by this deficient practice. (B) An audit of all residents that are on toilet plans will be conducted to monitor the effectiveness of the plan. Assessments, voiding diaries and corrections will be	05/06/2016	

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F 315	Continued From page 32  This REQUIREMENT Is not met as evidenced by: Based on record review and interview it was determined that for one (R131) out of 32 sampled residents the facility failed to consistently monitor a toileting program and failed to identify the need for the toileting plan to be re-assessed. Findings include:  The following was reviewed in R131's clinical record;  10/24/15 - 10/26/15 - Bowel and Bladder Evaluation documented all opportunities as continent except three episodes of being wet.  10/30/15 - Admission MDS documented the resident was moderately impaired for decision making, needed limited assistance with toileting, was not on a toileting plan. This assessment incorrectly documented that R131 was continent of urine instead of occasionally incontinent of urine.  Review of R131's ADL Flow Record found:  October, 2015 - Incorrectly documented that the resident was always continent.  11/1/15 - 11/9/15 - Documented as being Incontinent on the night shift daily, once on day shift and once on evening shift.  11/9/15 - A toileting schedule was started for the night shift to toilet R131 at 12:00 AM and 5:00 AM.	F 315	F315 (cont.) 2. (B) (cont.) conducted accordingly. 3. (A) The Staff Developer will educate the certified nursing assistants on the need to document the effectiveness of a resident's toileting plan. (B) The Staff Developer will re-educate licensed nurses on the facility's bowel and bladder program. (C) The MDS coordinator will take Relias training "MDS 3.0 Section H Bladder and Bowel". (D) Now during the morning meeting the DON/designee and Unit nurse manager(s) will review voiding dairies as team in order to develop an effective toileting plan. 4. Monthly DON/designee will audit 20% of all toileting plans for effectiveness. The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.		

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F 315	<p>Continued From page 33</p> <p>November, 2015 - Staff failed to monitor the effectiveness of the toileting program 13 out of 42 times. The program was documented as ineffective on the other entries. It was documented that R131 was always Incontinent on the night shift.</p> <p>December, 2015 - Staff failed to monitor the effectiveness of the toileting program 28 out of 62 times. The program was documented effective on one shift and ineffective for all the rest. The resident was coded as being always incontinent on the night shift.</p> <p>January, 2016 - Staff failed to document the effectiveness of the toileting program 12 out of 60 times. The program documented effective 8 shifts and Ineffective for all the rest. The resident was coded as being always incontinent on the night shift.</p> <p>February, 2016 - Staff failed to document the effectiveness of the toileting program 21 out of 58 times. The program was ineffective the rest of the shifts. The resident was coded as always being incontinent on the night shift.</p> <p>1/23/16 - A care plan problem for incontinent of bladder with potential to improve control or management included the approaches to assist with toileting needs and to toilet on night shift at midnight and 5:00 AM.</p> <p>1/28/16 - Quarterly MDS Assessment documented R131 required extensive assistance with toileting, was on a toileting plan and was frequently Incontinent. There was no evidence that the resident's bladder incontinence was reassessed at the time of the assessment or if</p>	F 315			

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F 315	Continued From page 34 the toileting program was re-evaluated.  An interview on 2/23/16 at 3:01 PM with E12 (CNA) revealed E12 checked the resident every two hours for toileting but the resident would often refuse to go to the bathroom and was often wet. E12 stated that when the resident was first admittted she would move around more but due to a heel wound R131 often refused to walk to the bathroom or use the bed pan.  An interview on 2/24/16 at 2:59 PM with E6 (RN, UM) confirmed that there was mlsingg documentation in the toileting schedule and that E6 would look for any additional assessment.  2/24/16 - A Bowel and Bladder Evaluation was Initiated with a four day voiding dlary.	F 315			
F 329 SS=E	483.25(I) 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	F 329	F329 1. The reason and response to R38's prescribed anxiety medication is now being documented per protocol. 2. All residents receiving PRN anxiety medication have the potential to be affected by this deficient practice. 3. (A) The Staff Developer will educate licensed nurses on the need to document both the reason and the response on the back of the PRN MAR's when anxiety medication is administered. (B) Now at the end of each shift the supervisor/designee will check the PRN MAR's to monitor that pain medicatlons were	05/06/2016	

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F 329	<p>Continued From page 35</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the drug regimen was free from unnecessary drugs for one (R38) out of 32 sampled residents by not recording the reason for administration or resident response to PRN antianxiety medication. Findings include:</p> <p>Cross Refer F309, example 1 Review of R38's clinical record revealed: 11/2/15 - physician orders included a medication to be given every 8 hours PRN for anxiety.</p> <p>Review of PRN MARs from November and December, 2015 and January, 2016 found the following administrations lacked documentation on the back of the MAR with no evidence as to the reason for these administrations nor resident response to the medication: - November, 2015: 12 out of 21 times (57%). - December, 2015: 8 out of 13 times (62%). - January, 2016: 3 out of 5 times (60%). One (1) entry 1/13/16 (5:30 PM) recorded on the back of the MAR was missing resident response to the medication.</p>	F 329	<p>F329 (cont.)</p> <p>3. (B) (cont.) administered and documented per protocol.</p> <p>4. Weekly the DON/designee will audit 20% of PRN MARs to ensure that medications were given per protocol. The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.</p>		

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F 329	Continued From page 36  Interview with E5 (RN, UM) on 2/25/16 at 10:00 AM reviewed the PRN MARs for this resident and E5 confirmed the missing assessments for this PRN antianxiety medication.	F 329			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/29/16 at 2:40 PM.  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.  (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.  (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 hands after each direct resident contact for which	F 441	F 441 1. The Infection Control Program is now up to date. 2. All residents have the potential to be affected by this deficient practice. 3. Now the Staff Developer/designee is given the responsibility to maintain the infection control program for the facility. On a monthly basis the program will include identifying clusters and/or trends. The Staff developer/designee will analyze data monthly and devise a corrective action plan as needed and maintain evidence of training conducted. 4. (A) On a monthly basis the DON/designee will review the infection control program and monitor for clusters, trends, corrective actions, and evidence of training. (B) The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.	05/06/2016	

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F 441	Continued From page 37 hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, It was determined that the facility failed to maintain an effective infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection by failing to analyze infection data that was collected. Findings include.  1. Record review of infection control data from February 2015 - January 2016, revealed that for 7 out of 12 months, infection control data was not analyzed. No report was created identifying clusters or trends and corrective actions after June 2015.  On 02/25/16 at 2:30 PM during an interview with E13 (RN), E13 confirmed that, after June 2015, infection control reports were no longer written.  2. Record review of the infection control data revealed that for 2 (February and May 2015) out of the 5 months infection control reports that were created, education was listed as a corrective action, but there was no evidence that these trainings took place.	F 441		

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F 441	Continued From page 38 On 2/25/16 at 2:30 PM during an interview with E13, it was confirmed that E13 had no record of the training sessions mentioned in the infection control reports.  Findings were reviewed with E1 (NHA) and E2 (DON) on 02/29/16 at 2:40 PM.	F 441		
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 it was determined that for 1 (R22) out of 32 sampled residents the facility failed to ensure all portions of the resident call system were functioning. Findings include:  Observation on 2/19/16 at 11:25 AM found R22's call bell would not activate. E8 (LPN) was immediately notified and the call bell was repaired the same day.  An observation was made on 02/23/16 at 11:52 AM of R22's call bell and again, it did not function. When observing the wall fixture, the surveyor discovered a piece of small folded paper wedged above the "Reset" button. This paper held the button down preventing the light from illuminating and alarm from sounding.  E1 (NHA) was informed of the discovery of the folded paper used to inactivate R22's call bell on	F 463	F463 1. R22's call bell is now functioning correctly. 2. All residents have the potential to be affected by this deficient practice. An all house audit of call bells will be conducted to ensure all call bells function properly. 3. (A) All staff will be educated regarding proper function of call bells, and that placing paper above the "Reset" button is not acceptable. (B) Now the maintenance director will place monitoring of the call bells function in the monthly preventive maintenance schedule. 4. (A) The maintenance director/designee will make weekly rounds on all call bells to monitor that paper is not placed above the "Reset" button. (B) The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.	05/06/2016

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F 463	Continued From page 39 2/23/16 around 2:50 PM.  These findings were reviewed with E1 and E2 (DON) on 02/29/16 at 2:40 PM.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and Interview it was determined that for three (R145, R131 and R1) out of 32 sampled residents the facility failed to maintain complete and accurate clinical records. Findings include:  Cross Refer F314, example 2  1. R145 was a newly admitted resident (1/14/16) who came from the hospital with a sDTI to the left heel. The following was reviewed in the clinical record;  1/19/16 - Geriatric Medicine	F 514 F514	(A) Documentation regarding R145 tissue types is now correct. R145 and heels are now off loaded with heels-elevating cushion and the resident's flow record indicates to offload both heels. (B) R131's MDS was coded as occasionally incontinent. A new toileting plan has been initiated for R131 and staff is documenting the effectiveness of the plan. 2. (A) All residents with wounds have the potential to be affected by this deficient practice. (B) All residents' wound documentation will be audited to monitor that the correct tissue type is documented. Corrections will be made accordingly. (C) Offloading for heels will be done with heels-elevating cushion versus blue boots. Physician's orders and care plans will be changed to read "offload heels with heels elevating cushion as resident tolerates". (D) All residents have the potential to be affected by this deficient practice. (E) An audit of all resident that are on toilet plans will be conducted to monitor the effectiveness of the plan. Assessments, voiding diaries and corrections will be conducted accordingly.	05/06/2016

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F 514	Continued From page 40 Consultants/Admission/Annual History and Physical lacked documentation of a left heel PU.  1/26/16, 2/8/16 and 2/18/16 - Geriatric Medicine Consultants/Progress Note lacked documentation of a left heel PU.  January, 2016 - Resident Flow Record documented approaches to off load heels in bed and to use a blue boot to left heel when in bed.  February, 2016 - Resident Flow Record documented only the blue boot to left heel. The approach to off load the heels did not carry over.  An interview on 2/29/16 at 10:30 AM with E2 (DON) confirmed the lack of complete documentation.  Cross Refer F315  2. The following was reviewed in R131's clinical record;  11/9/15 - A toileting schedule was stated for the night shift to toilet R131 at 12:00 AM and 5:00 AM.  The staff failed to document the effectiveness of the toileting program:  November, 2015 - 13 out of 42 opportunities.  December, 2015 - 28 out of 62 opportunities.  January, 2016 - 12 out of 60 opportunities.  February, 2016 - 21 out of 58 opportunities.	F 514	F514 (cont.)  3. (A) The facility will train the wound nurse/licensed nurses on Relias, "About wound care: identification and assessment". The wound nurse and a unit nurse manager(s)/designee will conduct weekly wound rounds for documentation accuracy. (B) The facility will change their protocol to off load heels with heels elevating cushion. (C) The Staff Developer will educate certified nursing aides and licensed nursing to off load heels with heels elevating cushion. (D) The Staff Developer will educate the certified nursing assistants on the need to document the effectiveness of a resident's toileting plan. (E) The Staff Developer will re-educate licensed nurses on the bowel and bladder program. (F) The MDS coordinator will take Relias training "MDS 3.0 Section H Bladder and Bowel". (G) Now the DON/designee and Unit manager(s) will review voiding dairies in morning meeting in order to develop an effective toileting plan.  4. (A) The DON/designee will monitor weekly that residents heels are being off-loaded with heels elevating cushion. (B) The wound consultant will provide weekly reports to the facility that includes tissue type.	

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B WING _____		(X3) DATE SURVEY COMPLETED  <b>02/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCHMAN VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 41</p> <p>An interview on 2/24/16 at 2:59 PM with E6 (RN, UM) confirmed that there was missing/incomplete documentation in the toileting schedule.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 2/29/16 at 2:40 PM.</p> <p>3. In January and February, 2016, R1 was incontinent and that was consistently documented on ADL Flow Record. The Resident Flow Record under section for "toilet before meals and bed" was incorrectly documented E (effective).</p> <p>The following were reviewed in R1's clinical record: January, 2016 - ADL Flow Record documented that the resident was always Incontinent on all 3 shifts. February, 2016 - ADL Flow Record documented that the resident was always incontinent on all 3 shifts.</p> <p>10/22/15 - Toileting schedule stated to "toilet before meals and bed".</p> <p>January, 2016 - Resident Flow Record for "toilet before meals and bed" was incorrectly documented E (effective) 100 out of 124 opportunities.</p> <p>February, 2016 - Resident Flow Record for "toilet before meals and bed" was consistently incorrectly documented E (effective) on all 3 shifts.</p> <p>An interview on 2/25/16 at 2:55 PM with E3 (ADON) confirmed that "E (effective)" on Resident Flow record means "resident was put on BSC [bedside commode] or toilet and urinated".</p>	F 514	<p>F514 (cont.)</p> <p>4. (cont.)</p> <p>(C) Monthly DON/designee will audit 20% of all toileting plans for effectiveness. The results of these audits will be reported out in monthly QAPI until 100% compliance is achieved.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 514	Continued From page 42  An interview on 2/29/16 at 10:30 AM with E2 confirmed that this documentation on R1 was not accurate.  These findings were reviewed with E1 and E2 on 2/29/16 at 2:40 PM.	F 514		



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

**STATE SURVEY REPORT**

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: February 29, 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><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey was conducted at this facility from February 18, 2016 through February 29, 2016. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 83. The survey sample totaled thirty two (32).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed February 29, 2016 F157, F241, F246, F252, F272, F278, F279, F309, F314, F315, F329, F441, F463, and F514</p>	<p>Cross Refer to the CMS 2567-L Survey Ext Date 2/29/16</p> <p>F157, F241, F246, F252, F272, F278, F279, F309, F314, F315, F329, F441, F463 and F514</p>	<p>RHJ</p> <p>5/6/16</p>

Provider's Signature Dean C. Reed Title Exec Dir Date 3/30/16