

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

PRINTED: 10/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2014
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from October 9, 2014 through October 16, 2014. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and twenty nine(129). The survey sample totaled twenty five (25) residents. Abbreviations used in this report are as follows: NHA- Nursing Home Administrator; DON - Director of Nursing; ADON- Assistant Director of Nursing RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide. ADL - Activities of Daily Living BIMS - Brief Interview of Mental Status	F 000		
F 225 SS=D	483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE *10/07/2014*

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 225	<p>Continued From page 1 other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R15 and R9) out of 25 sampled residents the facility failed to immediately report to the state agency allegations of abuse, mistreatment or misappropriation of property. Findings include: The facility's policy Incident Reporting System documented reportable incidents shall be communicated immediately and shall be reported</p>	F 225 Individual/ Resident Impacted Identification of other residents with the potential to be affected System Changes	<p>F225 Investigate/Report Allegations/Individuals</p> <p>Item 1a DON confirmed incident report was written regarding R15's 6/8/14 allegation of \$20.00 being missing from his wallet and the incident was reported to DLTCRP on 6/10/14. R15's plan of care indicates that he makes false accusations regarding staff and/or care. It was also confirmed that this resident has a locked drawer in his room for storage of personal items and has the ability to secure possessions, but refuses to do so.</p> <p>Item 1b DON confirmed that there was an incident report written on 8/13/14 which stated that R15 reported a missing a \$70.00 money order. It was not reported to DLTCRP unit 8/15/14. Data provided by the Patient Resource department demonstrated that R15 purchased a money order for \$19.95 and a \$0.49 stamp in June and there was no record of a money order for \$70.00 in August.</p> <p>Item 2 DON confirmed that there was an incident report written on 12/8/13 that R9 accused a staff member of abuse. DHCI Security officer was also called during this incident. DLTCRP was not notified of this allegation until 12/11/13. After review of medical record this resident has a plan of care which states the she history of making false allegations toward staff. This allegation of abuse was not substantiated by DLTCRP.</p> <p>Item 1a and Item 2 All residents have the potential for this deficient practice when verbalizing any allegation to staff.</p> <p>Item 1a and Item 2 Nursing staff will continue to remind R15 to place valuables in locked drawer or deposit with the Patient account department.</p>	

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F 225	<p>Continued From page 2</p> <p>within 8 hours to the Division of Long Term Care Resident's Protection (DLTCRP - state agency). The DLTCRP Incident Report web site shall be used as the method of reporting when submitting a "reportable" incident.</p> <p>1a. Review of an incident report for R15 dated 8/8/14 documented; resident called nurse into room and stated he was missing \$20.00 from his wallet. He noticed this on 8/8/14 at 2400 [midnight]. He stated he placed the wallet on his bedside table and noticed on 8/9/14 that money was missing.</p> <p>Review of the web intake and the printed incident report revealed that the state agency was notified on 8/10/14.</p> <p>1b. Review of an incident report dated 8/13/14 for R15 documented; resident reported during care he realized yesterday that he was missing \$70.00 stated he had not reported it. Per supervisor's comments, resident states he had a money order for \$70.00, it was in a cloth bag, CNA bathed him, and now his bag is empty. Security was notified. Investigation in progress. Family only wants to be notified about emergencies.</p> <p>Review of the web Intake tracking and the printed incident report it was documented that the state agency was notified two days later on 8/15/14.</p> <p>An Interview on 10/13/14 at 3:45 PM with E6 , Quality Assurance Administrator, revealed that she had no further information and that the delay in reporting was probably right.</p> <p>Findings were reviewed with E1, NHA and E2,</p>	F 225	<p>Email (Attachment 1) was sent to all nursing supervisors on 10/24/14 reminding them when making rounds to review the IR folder/clipboard on each unit for possible reportable incidents as well as reporting off to the next shift if an incident had been reported to DLTCRP.</p> <p>Nursing Supervisors will be reminded that if their initial investigation within 8 hours is inconclusive ie neglect, abuse, financial exploitation etc. that the event should be sent to DLTCRP.</p> <p>Nursing Supervisors will also be reminded that DHC1 incident report form has check at the top of the form if event was a reportable incident or not a reportable incident which is not consistently being checked off for either choice.</p> <p>Nursing Supervisors will attend a refresher in-service regard all reportable incidents provided by the DHC1 Quality Assurance department.</p> <p>Item 1 and Item 2</p> <p>Nursing Supervisors will send reportable incidents to DLTCRP's web-intake system within 8 hours and forward electronic communications to the Facility Director, Quality Assurance, and Nursing Administration. Quality Assurance will monitor this area for the next three weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>Next, Nursing Supervisors will send reportable incidents to DLTCRP's web-intake system within 8 hours and forward electronic communications to the Facility Director, Quality Assurance, and Nursing Administration. Quality Assurance will monitor this area for the next two weeks until the facility reaches 100% over the next three consecutive evaluations.</p> <p>Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.</p>	11/30/14

Success Evaluation

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F 272	<p>Continued From page 5</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 for two (R16 and R15) out of 25 sampled residents the facility failed to ensure the accuracy of the comprehensive assessment by failing to conduct resident interviews when the resident is capable of participating. Findings include:</p> <p>1. R16 had an annual MDS assessment dated 6/22/14. The MDS documented the resident had a BIMS (mental assessment) evaluation which scored 15 on a scale of 0-15 indicating he was cognitively (mental abilities related to memory) intact.</p> <p>However, on the MDS in the section for Pain Assessment Interview, the staff person conducting the assessment did a staff observation instead of a resident interview.</p> <p>A quarterly MDS assessment dated 8/14/14 was conducted again with a resident interview for the BIMS (15) but a staff observation was done for</p>	F 272	<p>Nursing staff will be in-serviced on the BIMS and what the scores of this mental status denote. This education will provide a basis for the nurses to determine if the resident can and should be interviewed for section J of the MDS.</p> <p>RNAC staff will review each MDS for the BIMS score and that section J of MDS is completed accurately, with either the resident being interviewed if score is 8 or greater or that there is documentation to support that resident denied the interview.</p> <p>Item 1 and Item 2 Quality Assurance will review MDS 3.0 assessments and nursing notes in the area of pain to determine if residents were interviewed. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>Quality Assurance will review MDS 3.0 assessments and nursing notes in the area of pain to determine if residents were interviewed. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.</p>	11/30/14

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F 272	Continued From page 6 pain. An interview on 10/14/14 at 9:50 AM with E18, RN, revealed that she completed the assessment and does not know why a staff observation versus a resident interview was done for pain. 2. R15 had an annual MDS assessment dated 1/16/14. The MDS documented the resident had a BIMS which scored 10 on a scale of 0-15 indicating his memory was moderately impaired. The resident interview of pain was also completed indicating pain in the last 5 days. A quarterly MDS dated 7/3/14 documented from a resident interview a BIMS score of 9 (moderately impaired) and a staff observation of pain was conducted indicating the resident had no pain. A quarterly MDS dated 9/25/14 documented from a resident interview a BIMS score of 8 (moderately impaired) and a resident interview for pain indicating the resident had pain in the past 5 days. An interview on 10/14/14 at 9:50 AM with E18, RN, revealed that she completed the assessment and does not know why a staff observation versus a resident interview was done. Findings were reviewed on 10/16/14 at 3 PM with E1, NHA and E2, DON.	F 272	F274 Comprehensive Assess After Significant Change Item 1 DON met with the RNAC staff on 10/17/14 to discuss why R24 did not have a significant change MDS completed when the resident entered Hospice Care. Per RNAC staff the late significant change MDS was due to a communication issue within the facility. During interview with RNAC it was also brought to DON's attention that the resident's care plan was updated to Hospice care on 2/13/14 and there was an initial hospice care meeting on 2/25/14 therefore, there was no negative impact regarding this resident and the care that was provided to him. The RNAC discovered the error on 4/1/14 and the significant change MDS was completed on 4/16/14. Once this break in communication was discovered, the Social Service department now includes the RNAC staff when a resident has been referred for Hospice Care. In addition, the finance office also sends an email to the RNAC office staff when a resident has been accepted into Hospice. Item 1 A sweep from April 2014 to current was completed on all residents who receive Hospice Care for the completion of a significant change MDS.	
F 274 SS=D	483.20(b)(2)(II) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined,	F 274		
		Individual/ Resident Impacted		
		Identification of other residents with the potential to be affected		

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F 274	Continued From page 7 that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R24) out of 25 sampled residents the facility failed to identify the need to conduct a significant change MDS assessment for this resident, who had elected hospice services. Findings include: Review of R24's clinical record revealed the following: 2/7/14- R24 was admitted to hospice services. The facility failed to identify the need to conduct a significant change MDS assessment when the hospice services were elected. Findings were reviewed with E5 LPN during an interview on 10/15/14 at 2:16 PM. Findings were reviewed with E1, NHA and E2, DON on 10/16/14 at 3 PM.	F 274 System Changes Success Evaluation	Item 1 DON determined that the root cause of this error was related to a breakdown in communication within departments at the facility. Once this breakdown was identified the facility was able correct the deficient practice as of April 2014. During the review of this deficiency and the follow up as to what transpired, it should be noted that shortly after the error was discovered back in April, DHCI took self-correcting steps to improve notification involving hospice care changes that have been successful in ensuring care plan updates for significant changes of residents' health care needs. Item 1 Quality Assurance will review MDS 3.0 assessments and determine if sections were completed to reflect hospice services for residents that had a significant change after readmission. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations. Quality Assurance will review MDS 3.0 assessments and determine if sections were completed to reflect hospice services for residents that had a significant change after readmission. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations. Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.	11/30/14
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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F 325	<p>Continued From page 8</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure a resident received a therapeutic diet by failing to administer an ordered dietary supplement for one (R115) out of 25 sampled residents. Findings include:</p> <p>R115's clinical record revealed the following:</p> <p>R115 had a physician's order to receive Nepro (a nutritional supplement for people who have kidney failure) 8 ounces through the feeding tube (a tube inserted in the stomach for those who are unable to swallow) if meal intake was less than fifty percent.</p> <p>August 2014 documentation of meal percentages indicated R115 consumed less than 50% during the 8/6 lunch meal, 8/29 breakfast and lunch and 8/30 lunch meal. The MAR where documentation of R115's meal percentage intake, and supplement administration intake was recorded was absent of documentation on the</p>	F 325	<p>F325 Maintain Nutrition Status Unless Unavoidable</p> <p>Item 1 Facility Nutritionist III reviewed R115 11/3/14 and recommended tube feeding regimen change increasing nocturnal feeding to 4 cans of Nepro daily via tube from 1900-0500, stopping the order for 1 can of Nepro via tube if meal intake was less than 50 percent, Facility Medical Director implemented Nutritionist III recommendations on 11/3/14.</p> <p>Item 1 R115 was the only resident in the facility with an order to receive a nutritional supplement via feeding tube, dependent on by mouth meal intake percentages. This order has since been discontinued.</p> <p>Item 1 In the future, any resident who has an order to receive a nutritional supplement via feeding tube based on oral meal intake percentages will be reviewed monthly, by facility staff RD for appropriateness and completion of MAR documentation.</p> <p>Item 1 All residents receiving nutritional supplementation via feeding tube based upon oral meal intake percentages will be reviewed monthly by facility staff RD and information will be given to facility Quality Assurance Administrator.</p> <p>Quality Assurance will review nutrition supplement documentation for R115. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations.</p>	11/30/14

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F 325	<p>Continued From page 9</p> <p>corresponding dates and times for 8/6, 8/29, and 8/30 indicating R115 did not receive the ordered supplement.</p> <p>September 2014 documentation of meal percentages indicated R115 consumed less than 50% during the 9/4 and 9/7 lunch meals, 9/10 and 9/12 breakfast meals, and 9/15 lunch meal. The MAR was absent of documentation on the corresponding dates and times for 9/4, 9/7, 9/10, 9/12 and 9/15 indicating R115 did not receive ordered supplement.</p> <p>October 2014 documentation of meal percentages indicated R115 consumed less than 50% during the 10/5 breakfast, 10/5 and 10/13 lunch meal. The MAR was absent documentation on the corresponding dates and times for 10/5, 10/13, indicating R115 did not receive the ordered supplement.</p> <p>On 10/15/14 at 2:50 PM during an interview with E21 LPN, it was stated that R115 "usually eats less than 50%, and at least once a shift has to receive the supplement." E21 further stated that when assigned she "definitely document's what percentage is eaten and how much of the supplement was taken."</p> <p>On 10/16/14 at 1:22 PM during an interview with E4 RN and head nurse on R115's unit, E4 denied any knowledge of missed documentation. E4 was unable to provide documentation that R115 received the ordered supplement when indicated by intake of less than 50%. E4 confirmed that nursing staff should be documenting and administering R115's supplement as ordered.</p> <p>Findings were reviewed with E1, NHA and E2,</p>	F 325	<p>Quality Assurance will review nutrition supplement documentation for R115. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.</p>	

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F 325	Continued From page 10 DON on 10/16/14 at 3 PM.	F 325	F328 Treatment/Care for Special Needs	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that proper treatment and care was provided to one (R71) out of 25 sampled residents. The facility failed to ensure staff practices were consistent with current respiratory care by leaving R71's nasal cannula (tubing used to deliver oxygen through the nostrils) oxygen tubing uncovered. Findings include: On 10/10/14 at 11:27 AM, an observation of R71's room revealed his nasal cannula oxygen equipment lying on top of the oxygen concentrator uncovered. In an interview on 10/10/14 at 11:28 AM, E4 RN confirmed the finding and stated that the nasal cannula tubing should be covered. E4 immediately discarded the nasal cannula oxygen	Individual/ Resident Impacted Identification of other residents with the potential to be affected System Changes Success Evaluation	Item 1 Upon notification of this deficient practice the Infection Preventionist RN began researching the best practices with regard to storage of oxygen tubing when not in use by a resident. The DON also began networking with other DONs throughout the state as to their facility practices. The Quality Assurance staff was able to locate a product to store the oxygen tubing when not in use. The DON was able to speak with a company representative and a package of 10 Infection Prevention Pouches was purchased to trial at the facility. Item 1 A sweep of those residents who only use oxygen intermittently was completed on 10/31/14. The remaining residents all received the trial product on 10/31/14. Item 1 An email (Attachment 2) from DHCI's Infection Preventionist was sent on 10/31/14 to all Head Nurses and Nursing Supervisors which included the instructions for the trial product and when to replace the product per the manufacturer recommendations. Nursing Policy 603 (Attachment 3) which is titled Oxygen Administration has been revised to include that staff are to store oxygen tubing when not in use in the protective pouch. Nursing department staff will be in-serviced by nursing administration on the revised nursing policy for oxygen administration. Item 1 Risk Manager will review nasal cannulas to ensure they are stored properly for residents that use oxygen. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations.	11/30/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2014
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977	
(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 328	Continued From page 11 tubing.	F 328	Risk Manager will review nasal cannulas to ensure they are stored properly for residents that use oxygen. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations.	
F 364 SS=E	Findings were reviewed with E1, NHA and E2, DON on 10/16/14 at 3 PM. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews and three of three test tray results, it was determined that the facility failed to serve food that was palatable. Findings include: 1. During an interview on 10/10/14 at 2:25 PM, R24 stated that the food "doesn't taste good". On 10/15/14 at 12:32 PM, a test tray was sampled on the 400 unit for flavor and palatability. The puree cheese steak and noodles were bland. The brown gravy was too salty. Findings were reviewed with E1, NHA and E2, DON on 10/16/14 at 3 PM. 2. During stage one confidential screening interviews 5 (A1, A2, A3, A4, and A5) out of 12 residents interviewed complained of receiving cold food.	F 364 Individual/ Resident Impacted Identification of other residents with the potential to be affected System Changes	Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem. F364 Nutritive Value/Appear, Palatable/Prefer Temp Item 1 Immediate Action taken to review and modify Puree Cheesesteak, Puree Noodles and Brown Gravy recipes. Seasoning was adjusted and recipes changed. Item 2 Immediate action was unable to be taken as cold food during mealtime not reported immediately to foodservice staff. Food Service Department has since started to prepare food in smaller batches and place smaller batches on the serving line in an attempt to preserve temperatures. Item 1 All residents at DHCI receiving puree diets have the ability to be affected by this deficient practice. Item 2 All residents at DHCI have the ability to be affected by this deficient practice. Item 1 Facility RD to address personal preferences of R24. R24 has been given a personal Salt and Pepper shaker so that resident may season food to his liking. R24 will be monitored by the QA department for ability to season food properly, make meal selections and have access to desired condiments. Monitoring of food preferences by the Facility RD will be done on a quarterly basis and preferences will be documented in R24 nutritional file. A systemic review of all puree recipes will be completed by 11/30/14.	11/30/14

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

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NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL FT CHRONICALLY ILL (DHC)			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977	
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F 364	Continued From page 12 Test tray observations were conducted on 10/15/14 during the lunch meal on Candee 5. The lunch trays were delivered to the unit at 12:27 PM. The testing was started at 12:37 PM when the last resident received their lunch. The following was observed: - Mechanical soft chicken with gravy was cool to taste with temperature readings of 111 to 114 F (Fahrenheit). - Regular diet tray broccoli cool to taste 105 F. - Mechanical soft diet broccoli cool to taste 105 F. Findings were discussed during the exit conference on 10/16/14 at approximately 3:00 PM with E1 and E2.	F 364	Item 2 Nursing will ask residents if their food is hot enough. If food not hot enough for resident liking, nursing staff will offer to reheat food items in the microwave, available on each unit. Nutrition Quarterly, Annual and Significant Change Assessment Form will be updated to include resident meal satisfaction documentation. Item 1 and Item 2 Risk Manager will meet with residents to determine if food is palatable and hot to taste. Results of their samplings will be forwarded to Quality Assurance. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations. Risk Manager will meet with residents to determine if food is palatable and hot to taste. Results of their samplings will be forwarded to Quality Assurance. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations. Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.	
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, interview and review of facility documentation, it was determined that the	F 514	Item 2 Findings will be tracked weekly for three months, by facility Nutritionist III and reported to facility Administrator, Quality Assurance Administrator, DON, ADON and Foodservice Director. After three months, findings will be tracked and reported monthly to facility Administrator, Quality Assurance Administrator, DON, ADON and Foodservice Director. Routine test trays will be conducted randomly on units once a week by Quality Assurance, Nutritionist III, Staff RD or the Food Service Director II.	

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F 514	<p>Continued From page 13</p> <p>facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete for one (R24) out of 25 sampled residents. Findings include:</p> <p>The facility's policy entitled "Assignment Record and Profile", last reviewed on 1/3/13, stated, " ... Purpose: ... document the care given to each resident on a daily basis ... All documentation on the Assignment Record should be done after task is completed and must be complete before the end of shift ... Each block will be initialed by the caregiver indicating the task has been completed ... "</p> <p>Review of the September 2014 Assignment Record for R24 revealed 19 out of 90 shifts lacked evidence of complete documentation.</p> <p>Review of October 1 - 14, 2014 Assignment Record for R24 revealed 14 out of 42 shifts lacked evidence of complete documentation.</p> <p>In an interview on 10/15/14 at 9:40 AM, with E4 RN confirmed the findings.</p> <p>Findings were reviewed with E1, NHA and E2, DON on 10/18/14 at 3 PM.</p> <p>2. R15's care plan and CNA's Assignment Record (used to document care provided) documented; No shower or tub bath due to resident's preference. Daily bed bath, was hair two x weekly. The record included boxes to document bed bath, shampoo, shave and nails.</p>	F 514	<p>F514 Res Records- Complete/Accurate/Accessible</p> <p>Item 1 DON reviewed current Assignment record for R24 on 10/21/14 and confirmed that there are "blanks" noted in medical record. DON met with staff on 10/21/14 for R24 to reinforce the importance of documenting when care is provided to the residents.</p> <p>Item 2 DON reviewed R15's Assignment record on 10/17/14 and confirmed deficient practice as "daily bed bath" was not documented as being completed by the nursing staff as noted on the care plan. DON met with the charge nurse on the afternoon of 10/17/14 regarding the current insufficient documentation. On 10/21/14 upon return to work, Head Nurse explained that staff had been documenting the bed bath with the section for "complete care with bath, oral hygiene etc", but did also note that the section on the Assignment Record which denoted bed bath was blank. R15's Assignment record was changed on 10/21/14 to include the bed bath documentation with the complete care with bath section. The new Assignment Record was placed in the C.N.A. Assignment Record book on 10/21/14.</p> <p>Item 1 A sweep of C.N.A. Assignment Records was completed regarding overall documentation which included the residents who receive Hospice Care.</p> <p>Item 2 A sweep of resident's who only receive bed baths was conducted.</p> <p>Item 1 From the chart audits completed by DON, she was able to determine that those residents who receive Hospice Care with an assigned Hospice C.N.A. had "blanks" on the days that the Hospice Staff provided the care. Sporadic blanks were also noted on the Assignment Records for which no definite root cause could be determined.</p> <p>Nursing Policy 400 (Attachment 4) titled "Assignment Record" will be reviewed and revised to provide staff instruction as to documentation requirements if resident receives Hospice Care.</p> <p>Nursing staff will be in-serviced by Nursing Administration regarding the importance of accurately completing the documentation which supports the care that is provided to their assigned resident.</p>	11/30/14

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F 514	<p>Continued From page 14</p> <p>Review of the Assignment Record documented;</p> <p>June 2014 - no documentation for bed bath, shampoo, shave or nail care.</p> <p>July 2014 - no documentation for bed bath, shampoo, shave or nail care.</p> <p>August 2014 - bed bath documented 8/3, 8/4, 8/9 8/10, 8/11 and 8/13 and nail care 8/1. The rest were blank.</p> <p>September 2014 - bed bath documented 8/1, 9/3, 9/4, 9/9, 9/10, 9/11, 9/13. The rest were blank.</p> <p>October 2014 - no documentation through 10/15/14.</p> <p>An interview on 10/14/14 at 11:10 AM with E19, CNA and E20, RN it was revealed that if the assignment sheet was not signed off it was an oversight by staff.</p> <p>Findings were reviewed with E1 and E2 on 10/16/14 at 3 PM.</p>	F 514	<p>Item 2 DON reviewed several Assignment Records for residents whose plan of care indicated that a daily bed bath was part of the assignment as well as discussing with the C.N.A.s the reason for the blank section for bath, shave, nails and was able to determine that it is partially due to previous education that they had received as well as the Assignment record being redundant regarding bathing care.</p> <p>The ADL care plan library regarding the unit of care which includes providing bathing care will be revised to eliminate confusion as to the correct way to complete the documentation.</p> <p>Nursing Staff will be in-serviced by Nursing Administration regarding the change in the ADL Library and instruction will be provided to the C.N.A.s on the correct method to document on the Assignment Record.</p> <p>Nursing staff will be in-serviced by Nursing Administration regarding the importance of accurately completing the documentation which supports the care that is provided to their assigned resident.</p> <p>Item 1 and Item 2 At least one resident's Assignment Record will be reviewed for each assigned CNA by the nurse prior to the end of each shift. The Assignment Record will be reviewed by the nurse for accuracy and completeness.</p> <p>CNA Assignment Record will be reviewed by the licensed nurse prior to the end of the shift for accuracy and completion. Results will be forwarded to Quality Assurance. This will occur over the next three weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>CNA Assignment Record will be reviewed by the licensed nurse prior to the end of the shift for accuracy and completion. Results will be forwarded to Quality Assurance. This will occur over the next two weeks until the facility reaches 100% success over three consecutive evaluations.</p> <p>Finally, the facility will measure our practices one more time a month later, if the facility is still 100%, then we will conclude we have successfully addressed the problem.</p>	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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Wilmington, Delaware 19806
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STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Delaware Hospital f/t Chronically III

DATE SURVEY COMPLETED: October 16, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced annual survey was conducted at this facility from October 9, 2014 through October 16, 2014. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and twenty nine (129). The survey sample totaled twenty five (25) residents.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA- Nursing Home Administrator; DON - Director of Nursing; ADON- Assistant Director of Nursing RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide. ADL - Activity of Daily Living BIMS- Brief Interview of Mental Status</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory</p>		
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Provider's Signature

[Handwritten Signature]

Title

[Handwritten Title]

Date

[Handwritten Date: 11/07/2014]



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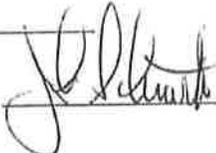
STATE SURVEY REPORT

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	<p>requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report ended October 16, 2014, F225, F253, F272, F274, F325, F328, F364 and F514.</p>	<p>Cross referenced to the CMS 2567-L survey report ended October 16, 2014, F225, F253, F272, F274, F325, F328, F364 and F514</p>	<p>11/30/14</p>

Provider's Signature  Title  Date 11/07/2014