

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

PRINTED: 12/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/24/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELAWARE HOSPITAL F/IT CHRONICALLY ILL (DHCI)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SUNNYSIDE ROAD SMYRNA, DE 19977</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from November 16, 2015 through November 24, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 137 (one hundred thirty seven). The Stage 2 sample totaled 26 (twenty six) residents.</p> <p>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;          UM - Unit Manager;          MD - Medical Doctor;          RNAC - Registered Nurse Assessment Coordinator;          CNA - Certified Nurse's Aide;          RD - Registered Dietitian;          NP - Nurse Practitioner;          PA - Physician Assistant;          SW - Social Worker;          SE - Staff Educator;</p> <p>ADLs - Activities of Daily Living, such as bathing and dressing;          BIMS (Brief Interview for Mental Status) - test to measure thinking ability [0-7= severe impairment; 8-12=moderate impairment; 13-15=cognitively intact];          CDC - Centers for Disease Control and Prevention;          D/C - Discontinue;          DPOA - Durable Power of Attorney-gives</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE \_\_\_\_\_  
*[Signature]* HOSPITAL DIRECTOR 1-26-16

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 someone the power to act in your place for medical care and finances; GDR - Gradual dose reduction; HVAC - Heating ventilation and air conditioning system; HS - At bedtime; MAR - Medication Administration Record (on paper); MDS - Minimum Data Set (standardized assessment used in nursing homes); PASRR - Pre-admission Screening Resident Review; POA - Power of Attorney-gives someone the power to act in your place; PRN - As needed; PU (Pressure Ulcer) - sore area of skin that develops when blood supply is cut off due to pressure; ROM - Range of motion, extent to which a joint can be moved safely; TAR - Treatment Administration Record (on paper); UTI - Urinary tract Infection;  Alzheimer's Disease - disorder resulting in loss of memory, thinking and language; Antidepressant medication-drugs used to treat depression and other conditions; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; Anxiety - general unpleasant state of feeling worry, nervous or restless; Anxiolytic - medication used to treat anxiety; Aphasia - neurological condition in which language function is defective or absent; Aspiration - inhaling food or fluid into the lungs; Ativan - medication to treat anxiety; Bacteria - very small germs that can cause disease;	F 000			

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F 000	Continued From page 2 Bipolar - mood disorder; Blood Pressure - measurement of the force of blood against blood vessel walls; Cognition - thinking ability; Continence - control of bladder and bowel; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and/or personality changes; Depression-mental disorder with feelings of sadness; Dysphagia - difficulty swallowing; Expressive aphasia - inability to express simple ideas in words or writing; G-tube (Gastrostomy Tube) - tube inserted into an opening into the stomach, can be used to give food and/or medications; Hospice - service providing care to residents who are terminally ill; Klebsiella - bacteria normally found in the intestines; Incontinence - loss of control of bladder and/or bowel; Physician Order Sheet (POS) - monthly report of resident's active physician orders; Puree diet - food ground into consistency like thick paste; Psychoactive drug-used to change brain function and results in alteration in perception, mood or consciousness; Psychosis - loss of contact/touch with reality; Psychological disorders-a wide range of conditions that affect mood, thinking and behavior; Psychotropic - medication used to treat psychosis; Psychopharmacological - medication used to treat psychological disorders; Seroquel - medication used to treat psychosis; Stage II (2) PU - skin blisters or forms an open	F 000		

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F 000	Continued From page 3 sore, area around the sore may be red and irritated; Stage III (3) PU - skin develops an open, sunken hole called a crater, with damage to tissue below the skin; Toileting program - scheduled times to encourage emptying of the bladder; UTI-urinary tract infection-bacteria in the urine.	F 000	<b>F252 – Safe/Clean/Comfortable/Homelike Environment</b>  The facility failed to provide a homelike environment during dining by serving meals on trays for three (Candee 3, 4 and 5) out of five dining rooms.  1. At management staff meeting on 12/9/15, it was determined that unit staff was unaware that individual dishes were to be removed from trays upon service. Director of Nursing and Registered Dietitian instructed all Nurse Managers to inform their staff that all dishes on trays were to be removed during meal service, unless resident expressed preference otherwise.	01/08/16	
F 252 SS=E	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 facility failed to provide a homelike environment during dining by serving meals on trays for three (Candee 3, 4, and 5) out of five dining rooms. Findings Include:  11/16/15 random observation of lunch served between 12:10 - 12:25 PM found the following number of residents received their meal on a tray and the dishes remained on the tray during the entire meal: - Candee 3: 16 out of 16 residents - Candee 4: 8 out of 9 residents - Candee 5: 8 out of 9 residents  11/23/15 at 11:08 AM interview with E7 (CNA on Candee 3) stated the trays were new and they leave the plates on the trays since, in the past	Individual/Resident Impacted  F 252  Identification of other residents with the potential to be affected  System Changes	All resident have the potential to be affected by this deficient practice. All residents were asked their dining preference in regards to having dishes removed from meal trays. This information was recorded on the Fine Dining Form (Attachments #1 through 5) that is located in the Nutrition Data Book on each unit.  The facility failed to provide a homelike environment for three (Candee 3, 4 and 5) out of five units, by not removing dishes from meal trays. The root cause for the deficient practice is knowledge deficit. The new tray system and process for enhanced dining was rolled out to Candee 2 to evaluate operational needs, barriers to success and develop a facility-wide process change. The QAPI team has drafted an expedited roll out of the program for the remaining four units in the facility. The Social Dining Team Action Plan details the expectation of the QAPI team (Attachment #6). The facility will take the following measures to ensure that meals are not served on trays (unless requested by the resident).  1. Selected staff from Candee 1, 3, 4 and 5 will cross train on proper dining service by observing meal service on Candee 2, which was not included in the deficient practice.		

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F 252	Continued From page 4 when removed, some residents threw them. E7 said they can't leave the salt and pepper on the tables since "you never know where they would end up". [Candee 3 is the locked unit for residents with memory problems]	F 252	<b>F252 - Continued</b> 2. Staff Development, in collaboration with the Registered Dietitian, will present a Social Dining In-service to all unit staff on Candee 1, 3, 4 and 5 by 1/8/16. 3. Dining Observation rounds will be made by management staff to ensure proper practice (Attachment #7).	
F 253 SS=E	These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM. <b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b>  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation It was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior on four (Candee 1, 2, 3, and 5) out of 5 units. Findings include:  Observations during Stage 1 (11/16/15 and 11/18/15 from 8:00 AM to 4:30 PM) and on an environmental tour on 11/20/15 from 3:05 PM to 3:50 PM and revealed the following:  -room 113: wall and trim damage; -room 116: stained wall; -100s bathroom: slow draining sink; -corridor between room 120 and 122: wall damage; -room 132: damaged bed side stand; -room 264: wall damage; -room 301: worn chair, damaged door frame; -room 304: wall damage, worn bed side stand;	Success Evaluation  F 253	Individual responsible for action:  Registered Dietitian, Food Service Director, and Nursing Administration will conduct random meal observation rounds weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. Finally, we will conduct meal observations one month later. If the facility is still compliant, then we will conclude that we have successfully addressed the deficient practice. All findings from Dining Observations and updates to Social dining Team Action Plan will be submitted to facility QAPI Team for evaluation and discussion at quarterly QAPI Meetings. The QAPI's team role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.  <b>F253 – Housekeeping &amp; Maintenance Services</b>  The identified examples of failure to maintain and provide a sanitary and comfortable interior were entered into the DMS AIM's system for corrective action on 12/16/15. (Attachment #8)  All residents have the potential to be affected by this deficient practice. Upon finding any failure to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior, staff will immediately submit work orders through the DMS AIMs system to correct the deficiency, and will also inform the Unit Manager and the LTC Section Safety/Environmental Officer and QA Director.	

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F 253	Continued From page 5 -room 306: wall damage; -room 307: damaged mirror, worn chair; -room 362: worn floor tiles; -room 506: wall damage; -room 510: dirty wall and wall damage; -room 517: damaged dresser; -room 520: damaged dresser and bed side stand;  Findings were reviewed with E9 (Director of Facility Operations) on 11/23/15 at 2:05 PM.  Findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.	F 253  System Changes  Success Evaluation	<b>F253 - Continued</b> Work orders are assigned to correct the identified issues by SDAAPD staff as required communication with the DMS staff. The AIM's System utilized by Facility Operations to identify, track and assign corrective actions for resident, staff and building requests will be generated following an environmental rounds approach between DSAAPD & DMS.  Inspections of the Candee Building are planned quarterly in an effort to identify normal wear and tear issues. This work order request system will also be relied on to identify and report areas that need maintenance work, repair and/or replacement. DSAAPD has appointed a liaison to participate on these inspections and track the progress in corrective actions on a quarterly basis. The DSAAPD Management Analyst and the Safety Officer will conduct monthly inspections of the entire Candee Building for three months beginning in January, 2016, to ensure that all work orders (including sound level adjustments) have been completed and 100% compliance achieved. Their findings will be logged and presented to the monthly Safety Committee and QA Committee as well as the quarterly QAPI Committee.	01/08/16	
F 258 SS=E	<b>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</b>  The facility must provide for the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain comfortable sound levels in one (Candee 3) out of 5 dining/activity/day rooms when the HVAC system was running. Findings include:  11/16/15 - During lunch observation the HVAC system turned on making it difficult to hear normal conversation while the equipment was running.  11/18/15 observation while seated near the lounge chairs where residents were watching television in the main activity/dining area revealed	F 258  Individual/Resident Impacted	<b>F258 - Maintenance of Comfortable Sound Levels</b>  The identified example of failure to maintain comfortable sound levels was entered into the DMS AIM'S system for corrective action (Attachment #9). The HVAC unit for the Candee 3 dayroom was replaced by Gale and Associates with a new Variable Frequency Drive Water Source Heat Pump and existing duct work was removed and replaced with a newly designed layout that removed all static discharge noise. Replacement was completed on 12/1/15. (Attachment #10)	12/01/15	

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F 258	Continued From page 6 HVAC turned on and ran for approximately 5 minutes at 9:25 AM, 10:06 AM, 10:49 AM, 11:19 AM, 11:40 AM. When the HVAC system was running the television could not be heard. The HVAC system turned on around every half hour.  11/19/15 observation while seated at the nurses station - radio able to be heard across the room. When the HVAC system was running the radio could not be heard and could not hear staff or residents talking across the room.  11/20/15 interview at 10:55 AM with E8 (LPN) revealed, the HVAC system "got loud last year after something was changed" on it. The nurse stated that E9 (Director of Facility Operations) was aware of the problem.  11/23/15 During an interview at 8:55 AM with E10 (LPN)-the nurse stated that last year there was a time when someone was yelling for help after a resident fell and no one heard.  11/23/15 interview at 9:05 AM with E9 - E9 stated the system was "old and efficient so there's no need to replace it. I haven't ignored it", it had been "checked out by our own staff as well as private contractors". When asked if the frequency of it running or the speed of the fan could be changed, E9 offered no answer.  These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.	F 258 <small>Identification of other residents with the potential to be affected</small>	<b>F258 - Continued</b> All residents have the potential to be affected by this deficient practice. Upon finding any failure to provide for the maintenance of comfortable sound levels in any area of any of the five Candee nursing units, staff will immediately submit work orders through the DMS AIMS system to correct the deficient, and will also inform the Unit Manager and the LTC Section Safety/Environmental Office and QA Director.  All units will be inspected monthly to ensure proper operations.  Quarterly inspections of the Candee Building are held using a team approach with DSAAPD and DMS staff to conduct environmental rounds quarterly in an effort to maintain normal wear and tear issues. DSAAPD has appointed a liaison to participate on these inspections and track the progress in corrective actions on a quarterly basis. The DSAAPD Management Analyst and the Safety Officer will conduct monthly inspections of the entire Candee Building for three months beginning in January, 2016, to ensure that all work orders (including sound level adjustments) have been completed and 100% compliance achieved. Their findings will be logged and presented to the monthly Safety Committee and QA Committee as well as the Quarterly QAPI Committee.		
F 272 SS=D	<b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized	<small>System Changes</small>  <small>Success Evaluation</small>          <small>Individual/Resident Impacted</small>	<b>F272 - Comprehensive Assessments</b>  <b>Item 1</b> The annual MDS assessment for R29 was coded inaccurately. The Unit Manager corrected the coding error on 12/03/15. Section (I) Oral/Dental status on the MDS was reviewed and found to be accurate.  <b>Item 2</b> The annual MDS assessment for R73 under section (J) Health Condition was inaccurately coded. R73 did have a fall on two separate occasions during the review period. The MDS assessment did not accurately reflect R73's status. The Unit Manager corrected the coding error on 11/20/15.		

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F 272	<p>Continued From page 7 reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and</p>	F 272	<p><b>F272 - Continued</b> <b>Item 3</b> The annual MDS assessment for R64 under section (O) Restorative Nursing Program was inaccurately coded. R64 was not in a restorative nursing program. The Unit Manager corrected the coding error on 12/12/15.</p> <p><b>Item 1</b> All other residents have the potential to be affected by the deficient practice of inaccurate assessment and documentation. A sweep of all other MDS section (L) was reviewed and found to be accurate. The Unit Managers and the Registered Nurse Assessment Coordinator (RNAC) will review all recent MDS's to ensure accuracy prior to submission.</p> <p><b>Item 2</b> All other residents have the potential to be affected by the deficient practice of inaccurate assessment and documentation. A sweep of all MDS's under section (J) Health condition was reviewed by Unit Managers and found to be accurate. The Unit Managers and the RNAC reviewed all recent annual MDS's to ensure accuracy prior to submission.</p> <p><b>Item 3</b> All other residents have the potential to be affected by the deficient practice of inaccurate assessment and documentation. A sweep of all MDS's under section (O) Restorative Nursing Program was reviewed by Unit Managers and found to be accurate. The Unit Managers and the RNAC reviewed all recent annual MDS's to ensure accuracy prior to submission.</p> <p><b>Items 1, 2 and 3</b> The LTC Section had self-identified weakness in their MDS coding accuracy. The LTC Section launched an MDS coding accuracy project that has been ongoing for the past six months. Through the initial audits they self-identified the need for additional staff trainings in RAI/MDS. The first phase of this training was completed over the past quarter (Attachment 13). In order to monitor the improvement in this area an MDS coding accuracy tool was developed and is now part of the LTC Sections QAPI approach (Attachment 14).</p>	

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F 272	<p>Continued From page 8</p> <p>interview It was determined that for three (R29, R73 and R64) out of 26 sampled residents the facility failed to ensure the accuracy of the MDS assessments during comprehensive review. Findings include:</p> <p>1. R29's clinical record revealed:</p> <p>12/11/14 - Annual MDS assessment documented R29 as none of the above present in the Oral assessment section, in response to the selection: no natural teeth or tooth fragments, mouth or facial pain, cavity or broken teeth.</p> <p>During an interview on 11/18/15 at 3:52 PM with R29, it was observed that she had no natural teeth and the resident reported she has not had teeth for "about 30 years".</p> <p>During an interview on 11/20/15 at 3:03 PM with E18 (RNAC) it was confirmed that the assesment response documented was an error.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 2/24/15 at 2:10 PM.</p> <p>2. R73's clinical record documented the resident fell on 8/21/15 and 9/21/15 without injury.</p> <p>10/8/15 Annual MDS assesment - documented the resident did not fall since her prior assessment dated 7/16/15 when, in fact, the resident had fallen twice.</p> <p>11/19/15 interview at 2:35 PM with E4 (UM) confirmed the resident did have two falls and confirmed the answer to the question "Has the resident had any falls since admision/entry or reentry or the prior assessment, whichever is</p>	System 272 Changes	<p><b>F272 - Continued</b></p> <p><b>Item 1</b></p> <p>The annual MDS assessment for R29 was coded inaccurately. The root cause for the inaccurate assessment is knowledge deficit and failure to review the resident's clinical record thoroughly. The facility will take the following measures to ensure accuracy of MDS coding:</p> <p>A. Complete refresher training for MDS 3.0 MDS power point, with instruction and examples (Attachment #11). This training will include all Unit Managers/designee on MDS coding by trained staff which includes RNAC, Staff Development Department or designee.</p> <p>B. At the end of each Inter-Disciplinary Team Meeting the care plan will be updated to reflect resident's current health status including dental needs and dietary changes due to changes in dental status or physical mobility.</p> <p>C. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy.</p> <p>D. The RNAC will review the MDS's one more time for coding accuracy prior to submission.</p> <p><b>Item 2</b></p> <p>The annual MDS assessment for R73 was coded inaccurately. The root cause for the inaccurate assessment is knowledge deficit and failure to review the resident's clinical record thoroughly. The facility will take the following measure to ensure accuracy of MDS coding:</p> <p>A. Complete refresher training for MDS 3.0 MDS power point, with instruction and examples (Attachment #11). This training will include all Unit Managers/designee on MDS coding by trained staff which includes RNAC, Staff Development Department or designee.</p> <p>B. At the end of each Inter-Disciplinary Team Meeting the care plan will be updated to reflect resident's current health status including mobility and review of current restorative program.</p> <p>C. All falls will be reviewed at least monthly at the Fall Committee Meeting.</p> <p>D. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy.</p>		01/08/16

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PRINTED: 12/09/2015  
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OMB NO. 0938-0391

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F 272	Continued From page 9 most recent?" was incorrect and should have been answered yes.  These findings were reviewed with E1 and E2 on 2/24/15 at 2:10 PM.  3. The following was reviewed in R64's clinical record:  8/27/15 - Annual MDS incorrectly documented the resident was on a restorative nursing program for passive ROM 7 days a week.  9/9/15 - Care plan review documented R64 refused ROM.  11/23/15 - Review of CNA documentation lacked evidence the ROM was being completed. Review of the physician orders lacked documentation of an order for ROM.  11/23/15 2:26 PM - Interview with E16 (RN, UM) revealed that R64 was not on a documented ROM program but that the CNAs try to move the resident's upper extremities during care daily. If was confirmed that the resident was not on a restorative nursing program for ROM.  These findings were reviewed with E1 and E2 on 11/24/15 at 2:10 PM.	F 272	<b>F272 - Continued</b> E. The RNAC will review the MDS's one more time for coding accuracy prior to submission.  <b>Item 3</b> The annual MDS assessment for R64 was coded inaccurately. The root cause for the inaccurate assessment is knowledge deficit and failure to review the resident's clinical record thoroughly. The facility will take the following measures to ensure accuracy of MDS coding: A. Complete refresher training for MDS 3.0 MDS power point, with instruction and examples (Attachment #11). This training will include all Unit Managers/designee on MDS coding by trained staff which include RNAC, Staff Development Department or designee. B. At the end of each Inter-Disciplinary Team Meeting the care plan will be updated to reflect resident's current health status including current mobility and restorative needs. C. All restorative documentation will be reviewed by supervisors to ensure accuracy and compliance. D. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy. E. Section (O) on the MDS assessments was corrected by RNAC and Unit Managers. Assessment on 12/15/15 found the MDS to be accurate. F. The RNAC will review the MDS's one more time for coding accuracy prior to submission.  <b>Item 1</b> Individuals responsible for Action: Nursing Supervisors or designees will conduct random audits of completed MDS's to ensure coding accuracy. Daily reviews of dental orders will be done to ensure accuracy of dental changes. Completed MDS's will be evaluated for coding accuracy weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated one more time. We will measure practices one month later. If facility is still compliant, then we will conclude that we have successfully addressed the cited deficient practice.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate	<b>F 278</b> Success Evaluation		

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F 278	<p>Continued From page 10 participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R64 and R139) out of 26 sampled residents the facility failed to ensure the accuracy of the MDS assessments during quarterly review. Findings include:</p> <p>1. The following was reviewed in R64's clinical record:</p> <p>6/4/15 - Quarterly MDS incorrectly documented the resident was on a restorative nursing program for passive ROM 7 days a week.</p>	F 278	<p><b>F272 - Continued</b> These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>Item 2</b> Individuals responsible for Action: Nursing Supervisors or designees will conduct random audits of completed MDS's to ensure coding accuracy as well as review falls daily in team meeting. Completed DMDS's will be evaluated for coding accuracy weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated on more time. We will measure practices one month later. If the facility is still compliant, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>Item 3</b> Individuals responsible for Action: Nursing Supervisors will conduct random audits of completed MDS's to ensure coding accuracy. All restorative documentation will be reviewed by supervisors to ensure accuracy and compliance weekly. Completed MDS's will be evaluated for coding accuracy weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated one more time. We will measure practices on month later. If the facility is still compliant, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p>		

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F 278	Continued From page 11 9/9/15 - Care plan review documented R64 refused ROM.  11/23/15 - Review of CNA documentation lacked evidence the ROM was being completed. Review of the physician orders lacked documentation of an order for ROM.  11/23/15 2:26 PM - Interview with E16 (RN, UM) revealed that R64 was not on a documented ROM program but that the CNAs try to move the resident's upper extremities during care daily. If was confirmed that the resident was not on a restorative nursing program for ROM.  These findings were reviewed with E1 (NHA) and E2 (DON) on 2/24/15 at 2:10 PM.  2. The following was reviewed in R139's clinical record:  3/18/15 - R139 was admitted with a Stage III PU to the right ankle and a diagnosis of Bipolar with pharmacological interventions.  9/3/15 - Quarterly MDS incorrectly coded R139 as having a stage II PU and the diagnosis of Bipolar was not included.  11/19/15 at 10:12 AM - Interview with E15 (RN, UM) confirmed that that the PU should have been coded as stage III and the Bipolar diagnosis was missing on the quarterly MDS.  These findings were reviewed with E1 and E2 on 11/24/15 at 2:10 PM.	F 278  Individual/Resident Impacted  Identification of other residents with the potential to be affected	<b>F278 – Assessment Accuracy/Coordination/Certified</b>  <b>Item 1</b> The quarterly MDS for R64 inaccurately documented that R64 was on a restorative nursing program for passive range of motion. The Unit Manager addressed the coding error on 12/16/15. The Unit Manager responsible for the inaccurate assessment received a one on one refresher training on MDS coding for Section (O) Special Treatments, Procedures and Programs on 12/15/15 (Attachment #12).  <b>Item 2</b> The quarterly MDS assessment for R139 incorrectly staged a pressure wound as a stage II when in fact R139 was admitted with a Stage III pressure wound to his right ankle. R139's quarterly MDS assessment was corrected on 11/26/15 to reflect accurate staging on the pressure ulcer wound and the missing diagnosis. The Registered Nurse responsible for the error was in-serviced on Section (M) Skin conditions on the MDS 3.0 on 12/12/15 (Attachment #12).  <b>Item 1</b> All other residents have the potential to be affected by the deficient practice of inaccurate assessment and documentation. A sweep of all resident's charts on a restorative program was reviewed and corrected on 12/16/15. Unit Managers and the RNAC reviewed all recent MDS's to ensure accuracy prior to submission on 12/31/15.  <b>Item 2</b> All other residents have the potential to be affected by the deficient practice of inaccurate assessment and documentation. A sweep of all residents who have pressure wounds was completed to ascertain that the correct staging of wounds was documented. A sweep of all residents with Bipolar diagnosis was completed on 12/16/15 to identify any missing from the MDS and corrective actions were taken as needed. Unit Managers and the RNAC reviewed all recent MDS's to ensure accuracy prior to submission on 12/31/15.		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279			

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F 279 SS=D	<p>Continued From page 12 <b>COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R2 and R139) out of 26 sampled residents the facility failed to ensure a care plan was developed for an identified need. R2 was receiving PASRR level 2 services due to a developmental disability that was not identified on the care plan. R139 was being treated for anxiety and Bipolar disorder that was not addressed in the care plan. Findings include:  Review of R2's clinical record revealed;  8/29/83 - R2 was admitted to the facility.</p>	F 279  System Changes	<p><b>F278 - Continued</b> <b>Item 1</b> The annual MDS assessments for R64 were coded inaccurately. The root cause for the inaccurate assessment is knowledge deficit. The facility will take the following measures to ensure accuracy of MDS coding: A. Complete refresher training for MDS 3.0 (RAI Manual) was completed on 12/15/15. Training will be presented via a power point presentation with instructions and examples (Attachment #11) and a one on one refresher course on specific coding methods. Participants of this training will include Unit Managers and all Registered Nurses on MDS coding. Training will be conducted by Staff Development, Director of Nursing (DON) and the RNAC. B. At the end of each Inter-Disciplinary Team Meeting the care plan will be reviewed to ensure that the care plan reflects resident's current health status and restorative care needs. C. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy. D. The RNAC will review the MDS's one more time for coding accuracy prior to submission.</p> <p><b>Item 2</b> The annual MDS assessment for R139 was coded inaccurately. The root cause for the inaccurate assessment is knowledge deficit. The facility will take the following measures to ensure accuracy of MDS coding: A. Complete refresher training for MDS 3.0 (RAI Manual) was completed on 12/15/15. Training will be presented via a power point presentation with instructions and examples (Attachment #11) and a one on one refresher course on specific coding methods. Participants of this training will include Unit Managers and all Registered Nurses on MDS coding. Training will be conducted by Staff Development, DON and the RNAC. B. At the end of each Inter-Disciplinary Team Meeting the care plan will be reviewed to ensure that the care plan reflects resident's current health status related to psychiatric diagnosis, skin integrity, treatments and interventions.</p>	01/08/16	

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F 279	<p>Continued From page 13</p> <p>12/13/12 - review completed by agency that serves the developmentally disabled documented that specialized services were appropriate. The specialized services for R2 was a community day program.</p> <p>5/27/15 - Resident care meeting notes documented that a representative from the developmentally disabled agency attended.</p> <p>11/20/15 - Review of the clinical record lacked evidence that a care plan had been developed addressing R2's developmental disability that included a day program away from the facility.</p> <p>11/20/15 10:28 AM - Interview with E15 (RN, UM) revealed that the resident goes to a community day program Monday through Friday but added she did not know what the resident does there. When asked how this program was incorporated into the care plan she stated that the day program has their own care plan and the facility does not have a copy. It was confirmed that the resident's case manager and/or a staff person from the day program do attend the resident care meetings.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:30 PM:</p> <p>2. Cross refer F329, Example #1.</p> <p>Review of R139's clinical record revealed;</p> <p>3/18/15 - R139 was admitted to the facility. Admission physician orders documented the use of an anxiety medication three times a day, an anti-depressant medication and an antipsychotic</p>	F 279  Success Evaluation	<p><b>F278 - Continued</b></p> <p>C. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy.</p> <p>D. The RNAC will review the MDS's one more time for coding accuracy prior to submission.</p> <p><b>Item 1</b> Individuals responsible for Action: RNAC, functional care summary nurse, supervisors or designee will be reviewing all restorative programs and evaluating the implementation of each individualized program. These evaluations will continue weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct monthly audits until we reach 100% success at three consecutive evaluations. If the facility is still in compliance, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>Item 2</b> Individuals responsible for Action: The Wound Care Nurse, Infection Prevention Nurse and Nursing Supervisors will conduct random audits of completed MDS's and the weekly wound sheet to ensure coding and documentation accuracy. These evaluations will continue weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct monthly audits until we reach 100% success at three consecutive evaluations. If the facility is still in compliance, then we will conclude that we have successfully addressed the cited deficient practice. These finds will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p>	

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F 279	Continued From page 14 medication to treat Bipolar symptoms twice a day.  5/5/15 - Care plan for alteration in emotional status: depression. Review of the care plan lacked evidence of approaches related to anxiety or Bipolar symptoms (beyond depression).  6/11/15 - Quarterly MDS documented an active diagnosis of Bipolar disorder.  11/20/15 10:38 AM - Interview with E15 (RN, UM) confirmed there was no care plan addressing anxiety or Bipolar disorder.  11/24/15 - Review of the facility's policy for Psychoactive Medications approved on 5/20/15 documented the following; - All residents on psychoactive medications must have the behaviors that the medication is intended to reduce and interventions incorporated into his or her care plan.  These findings were reviewed with E1 and E2 on 11/24/15 at 2:10 PM.	F 279  Individual/ Resident Impacted	<b>F279 – Develop Comprehensive Care Plans</b>  <b>Item 1</b> The facility failed to ensure an appropriate care plan was developed related to resident's disability and outside program. Although R2's Preadmission Screening (PASRR) indicated level (2) services due to a developmental disability, the facility care plan did not address the need of R2's disability that included a day program away from the facility. R2's care plan was reviewed and revised by the Social Services Director on 11/23/15. The care plan now reflects resident's current health status including the day program that R2 attends.  <b>Item 2</b> R139's clinical record did not reflect both pharmacological and non-pharmacological interventions. The care plan was revised by the Unit Manager on 11/26/15 to include non-pharmacological and pharmacological approaches related to R139's clinical symptoms. Immediate corrective action was taken by adding appropriate approaches to the care plan to reflect current resident health status.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	Identification of other residents with the potential to be affected F 280  System Changes	<b>Item 1</b> All other residents have the potential to be affected by the deficient practice. A sweep was completed on all PASRR level (2) resident charts on 12/16/15 to ensure that the care plans were updated to include other services received from outside programs due to developmental disability.  <b>Item 2</b> All other residents with psychiatric diagnosis or on psychotropic medications have the potential to be affected by the deficient practice. A sweep was completed by both Pharmacy and Nursing to ensure no other residents with psychiatric diagnosis and on psychotropic medications was impacted by this deficiency.  <b>Item 1</b> The facility failed to initiate a care plan for residents receiving specialized services due to developmental disabilities. The root cause was a knowledge deficit in how to manage the ongoing care plan process.	

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F 280	<p>Continued From page 15</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and Interview it was determined for for two (R57 and R64) out of 26 sampled residents the facility failed to invite the resident to participate in the planning of their care and for two (R57 and R120) out of 26 sampled residents the facility failed to revise the care plans to reflect their current status. Findings include:</p> <p>1. The following was reviewed in R64's clinical record;</p> <p>6/1/15 - A copy of a letter sent to R64's POA inviting her to a plan of care meeting on 6/17/15.</p> <p>6/4/15 - Quarterly MDS documented a BIMS score of 15 on a scale of 0-15 indicating intact mental status.</p> <p>6/16/15 - Plan of care meeting conducted, neither the resident or her POA attended.</p> <p>8/27/15 - Annual MDS documented a BIMS score of 15.</p> <p>8/17/15 - A copy of a letter sent to R84's POA inviting her to a plan of care meeting on 9/9/15.</p>	F 280	<p><b>F279 - Continued</b></p> <p>To ensure that resident's plan of care are updated and revised periodically, the facility will take the following measures:</p> <p>A. The Interdisciplinary team retraining was initiated and completed on 12/15/15 to include the MDS 3.0 (RAI Manual). Training was presented via a power point presentation with instructions and examples (Attachment #11). Participants of this training included Unit Managers, Social Services and all Registered Nurses on MDS coding. Training was conducted by the RNAC.</p> <p>B. The Interdisciplinary team will be retrained in the RAI Care Planning Sections.</p> <p>C. The facility Interdisciplinary team will review/revise the Long Term Care section's Care Planning Policy and in-service the team members.</p> <p>D. At the end of each Inter-Disciplinary Team Meeting the care plan will be reviewed to ensure inclusion of current PASRR level (2) services.</p> <p>E. The Unit Managers, Social Services and Nursing Supervisors will meet weekly during the Inter-Disciplinary Team Meeting to discuss resident's PASRR levels and related outside services. The care plan will be updated and revised to include these services.</p> <p><b>Item 2</b></p> <p>The facility failed to ensure the resident's care plan was accurate and updated to reflect the resident's current non-pharmacological and pharmacological approaches. A new nursing policy and procedure addressing psychoactive medications and behavior monitoring has been developed and implemented on 12/04/15 (Attachment #15). Training on Policy 1604 was conducted by DON and ADON.</p> <p>A. The Unit Managers and the Nursing Supervisor of designee will meet weekly during the Inter-Disciplinary Team Meeting to discuss related care plan issues, including documentation on the behavior monitoring flow sheets to ensure that care plans are updated.</p>	01/08/16

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F 280	<p>Continued From page 16</p> <p>9/9/15 - Plan of care meeting conducted, neither the resident or her POA attended.</p> <p>11/16/15 - Interview with R64 revealed that she had not been asked to participate in her care planning meetings.</p> <p>11/23/15 2:12 PM - Interview with E17 (SW) revealed that R64 is not her own decision maker because she has a DPOA.</p> <p>11/23/15 2:30 PM - Interview with E16 (RN, UM) revealed that it was not a practice to include the resident in the planning of care meeting because she had a DPOA.</p> <p>R64 was totally alert, oriented and mentally intact and had a DPOA in place to make medical decisions in the event she could not or did not want to make her own decisions. The facility failed to invite the resident to participate in her care planning.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 2/24/15 at 2:10 PM.</p> <p>2a. The following was reviewed in R57's medical record;</p> <p>2002 - R57 was in an accident and legally declared incompetent through the court system.</p> <p>6/22/15 - R57's guardian was sent a letter to attend a care planning meeting on 7/15/15.</p> <p>7/2/15 - Quarterly MDS documented a BIMS score of 13 on a scale of 0-15 indicating intact mental status.</p>	F 280	<p><b>F279 - Continued</b></p> <p>B. The facility will identify all residents on psychoactive medications and will ensure that the care plans are updated to include pharmacological and non-pharmacological approaches related to the specific use of medications, including a review of behavior monitoring sheets.</p> <p>C. At the end of each Inter-Disciplinary Team Meeting the care plan will be reviewed to ensure inclusion of active diagnosis and current psychoactive medications and documented approaches for each related behavior.</p> <p><b>Item 1</b> Individuals responsible for Action: Nursing Administration, Nursing Supervisors and Unit Managers will conduct random audits to ensure care plan updates. Nursing will be notified of all residents in an outside program by Social Services weekly. Audit results will be evaluated for compliance weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three consecutive evaluations. Finally, we will measure practices one month later. If the facility is still in compliance, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the quarterly Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>Item 2</b> Individuals responsible for Action: Nursing Administration, Nursing Supervisors and Unit Managers will conduct random audits to ensure care plan updates. Nursing will review all new and discontinued orders of psychotropic medications weekly. Behavior flow sheets will be audited for accuracy and completion, with adjustments to the plan of care as indicated. Audit results will be evaluated for compliance weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three consecutive evaluations.</p>		

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F 280	<p>Continued From page 17</p> <p>9/22/15 - R57's guardian was sent a letter to attend a care planing meeting on 10/7/15.</p> <p>9/24/15 - Annual MDS documented a BIMS score of 14.</p> <p>11/16 - 11/20/15 - R57 was observed daily to be independent in activities of daily living, self-directed in daily activity pursuits and observed smoking independently outside.</p> <p>11/19/15 10:15 AM - Interview with E15 (RN, UM) revealed the resident does not attend his care planning meetings but she [E15] does not know if he is invited. It was revealed that the resident is at a higher mental function now then he was years ago when he was first admitted.</p> <p>11/19/15 10:30 AM - Interview with E17 (SW) revealed that because the resident had been deemed mentally incompetent in 2002 he was not invited to the care planning meetings. E17 confirmed that R57 has improved mentally since he was admitted.</p> <p>11/23/15 11:20 AM - Interview with the resident revealed that he would like to be asked to attend his care planning meetings and would go if he was asked.</p> <p>The facility failed to include R57 in basic decisions in planning his care.</p> <p>These findings were reviewed with E1 and E2 on 2/24/15 at 2:10 PM.</p> <p>2b. The following was reviewed in R57's clinical record;</p>	F 280	<p>F279 - Continued Finally, we will measure practices one month later. If the facility is still in compliance, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance committee meeting (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>F280 – Right To Participate Planning Care – Revise CP</b> <b>Item 1</b> Two residents were identified during the survey (R57 and R64) as not being invited to attend their individual care planning meetings. Both residents expressed to the surveyors that they would have interest in attending their care plan meetings if asked. Social Services developed a new policy/procedure with regards to how the residents are to be invited to attend their care plan meetings on 12/11/15 (Attachment #16). Though R64 is adjudicated incompetent he still verbalized that he wished to attend his care plan meeting. A special care plan meeting was held on 12/18/15 with the resident present. His care plan was reviewed with him and he was informed that he will receive invites to his care plan meetings each time they come up for review. His next regular Individual Care Plan meeting took place on 12/30/15 and the resident was invited to attend.</p> <p><b>Item 2A</b> Two residents were identified during the survey (R57 and R64) as not being invited to attend their individual care planning meetings. Both residents expressed to the surveyors that they would have interest in attending their care plan meetings if asked. Social Services developed a new policy/procedure with regards to how the residents are to be invited to attend their care plan meetings on 12/11/15 (Attachment #16).</p>	

Individual/  
Resident  
Impacted

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F 280	<p>Continued From page 18</p> <p>9/4/15 -Annual MDS documented the following interests were very important; music, favorite activities, outdoors.</p> <p>9/18/15 - Activity Assessment documented; -resident expressed interest in trips "anything that gets me out of here"; -outside: playing pool, bingo, walks, the fishing pier, trips, special entertainment, socialization (select few), movies, listening to music and radio station 92.9 FM.</p> <p>3/27/07 last reviewed 10/7/15 - Care plan for activities included; -does not sit in a group well without getting ansy, likes to shoot pool, 1:1, motorcycles, rock and roll music, trivia, NASCAR, craft shop for pool, books and magazines on car/motorcycle.</p> <p>11/23/15 11:20 AM - Interview with E15 confirmed the care plan was not updated to reflect the current activity assessment that included trips and outdoor activities.</p> <p>These findings were reviewed with E1 and E2 on 2/24/15 at 2:10 PM.</p> <p>3. The following was reviewed in R120's medical record;</p> <p>R120 was admitted to the facility 11/8/11 for long term care.</p> <p>8/12/15 - care plan initiated for palliative care - comfort measures.</p> <p>11/6/15 - admitted to hospice service with initiation of a care plan by hospice.</p>	F 280	<p><b>F280 - Continued</b> Since R57 had expressed interest in being invited to her care plan meetings a special care plan meeting was held on 12/18/15 with the resident present. The care plan was reviewed and that resident was informed of the changes to the process of how residents are invited to attend their care plan meetings. The resident was informed that their next regularly scheduled care plan meeting would take place again in March 2016.</p> <p><b>Item 2B</b> R57's care plan was not updated to reflect interests that were identified by MDS as very important to the resident. This included trips off campus and outdoor activities. The care plan was revised by the Activity Therapist on 12/11/15 to reflect R57's interests of going outdoors and going on trips.</p> <p><b>Item 3</b> R120 was admitted to hospice on 11/6/15, however on 11/18/15 a review of R120's care plan showed no evidence of hospice care plan being initiated. The facility failed to initiate appropriate hospice care plan. A hospice care plan was developed and initiated on 11/19/15.</p> <p><b>Items 1and 2A</b> Social Services staff will be conducting a sweep of resident previous MDS forms on all units in order to create a tracking sheet that will document the resident's ability to complete the interview sections (C, D and Q) of the MDS and their score on the BIMS (Section C). Any resident, who is identified as being able to complete the interview sections, defined as scoring a 3 or above on the BIMS, will be invited to attend their care plan meetings. The sweep and the completion of the tracking spreadsheet were completed on 12/18/15. The Social Services staff was instructed on 11/21/15 by the social Services Administrator that all residents who are verbal and able to complete the interview sections of the MDS (Sections C, D and Q) are to be invited to attend their care plan meetings.</p>	

Identification of other residents with the potential to be affected



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F 309	<p>Continued From page 20</p> <p>90 degrees during meals/snacks and for 30 minutes after eating.</p> <p>8/13/15 quarterly MDS - documented the resident had severe cognitive impairment and was totally dependent on staff for eating.</p> <p>9/28/15 physician order - puree diet with honey thick liquid, feed at 90 degree sitting position.</p> <p>10/13/15 resident profile (eating section) in CNA documentation binder included: puree diet with extra sauce and gravy, honey thick liquids, staff to feed, allow ice cream. There was no mention that the resident was to be at a 90 degree angle.</p> <p>11/16/15 at 12:15 PM observation - R136 was at 90 degrees in his chair while being fed lunch.</p> <p>11/18/15 at 9:15 AM observation - R136 had empty breakfast dishes on the bedside table [had already eaten] and coughed while E12 (CNA) fed the resident thickened liquid from a cup. The head of the resident's bed was raised to approximately 35-45 degrees and not the 90 degrees as ordered.</p> <p>11/19/15 at 8:55 AM observation - the hospice aide was feeding R136 the last few bites of his breakfast and gave the resident the last of his fluids from a cup. No coughing was observed. The head of the bed was around 60 -70 degrees and not the 90 degrees ordered.</p> <p>11/19/15 at 2:50 PM interview with E13 (LPN) confirmed that R136 should be at 90 degrees for meals. When asked how the CNA's are monitored to assure the care plan is followed, the LPN stated she does not follow behind the CNAs</p>	F 309	<p><b>F280 - Continued</b></p> <p><b>Item 3</b></p> <p>The facility failed to initiate a hospice care plan on admission. The root cause of this care plan error was failure to review R120's clinical records for accuracy of resident's current health status. In order to avoid a repeat of the care plan error, the facility will take the following measures:</p> <p>A. Unit Managers/Nursing Supervisors will review physician orders related to residents being admitted into Hospice Care to ensure the initiation of a Hospice Care plan.</p> <p>B. All new orders will be reviewed on a daily basis by Nursing Supervisors and documented on House report of New Orders daily. This report will be reviewed by Supervisors and Nursing Administration on a weekly basis continuously.</p> <p><b>Items 1 and 2A</b></p> <p>The social Services Department staff received training on the new procedure on 12/11/15. It was conducted by the Social Services Administrator. A tracking sheet has been created for the case managers to update weekly after completing their MDS's that will list all residents in the facility, their unit location, their verbal ability, their BIMS score on the MDS, whether the case manager asked them to attend their care conference meeting (any resident that is able to be interviewed and score at least a 3 on the BIMS will be asked if they wish to attend their care plan meeting), the resident response and whether nursing was notified if the resident wishes to attend their care conference. The social Services Administrator will review this tracking device weekly to make sure it is updated and followed through on. This will be ongoing with no expected end date.</p> <p><b>Item 2B</b></p> <p>Individuals responsible for Action: A minimum of 10 resident care plans will be reviewed by the Activity therapy Program Coordinator weekly to ensure the residents interests stated in their current activity assessment are reflected in the active care plan. Audit results will be evaluated for compliance weekly for 16 weeks or until facility reaches 100% success over 12 consecutive evaluations.</p>	

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F 309	Continued From page 21 and just "takes it that they do what is signed off". E13 was informed of the two meal observations when the head of the bed was not at 90 degrees. E13 stated she would pass the information in report to position the resident at 90 degrees.  11/19/15 at 3:10 PM Interview with E4 (UM) was informed of the observed positioning during meals provided in bed and stated she would look into it.  11/20/15 at 9:05 AM observation - Resident was finished breakfast and was in a chair at approximately 80-90 degrees.  11/20/15 review of the resident's record - R136 had no episodes of aspiration within the past 6 months.  11/23/15 at 12:15 PM observation - R136 upright between 80-85 degrees in his chair while being fed lunch.  The facility failed to position R136 at 90 degrees in bed for two random meal observations.  These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.	F 309	<b>F280 - Continued</b> Finally, we will continue to measure practice for an additional month, if the facility is still in compliance, then we will conclude that we have successfully met our goal. Audit findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.  <b>Item 3</b> An audit of all residents with orders for comfort care or hospice orders will be reviewed by Nursing Supervisors, RNAC, or designee on a bi-weekly basis to ensure appropriate documentation and care plans are in place. Audit results will be evaluated for compliance weekly for 16 weeks or until facility reaches 100% success over 12 consecutive evaluations. Finally, we will continue to measure practice for an additional month, if the facility is still in compliance, then we will conclude that we have successfully met our goal. Audit finds will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.  <b>F309 - Provide Care/Services for Highest Well Being</b>  The facility failed to follow the physician order for positioning during meals to reduce the chance of aspiration for one (R136) out of 26 sampled residents. R136's profile in CNA documentation binder was updated to include feed at 90 degrees on 12/11/15.  All residents with orders for positioning during meals have the potential to be affected by this deficient practice. A sweep of resident care plans and profiles was completed on 12/31/15 to ensure accuracy with physician orders for position during meals.		
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		<b>Individual/ Resident Impacted</b>  F 314  <b>Identification of other residents with the potential to be affected</b>		

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F 314	<p>Continued From page 22</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R139) out of 26 sampled residents the facility failed to ensure a resident with a pressure ulcer (PU) received the treatment and services to promote healing. For R139, the facility failed to do a weekly PU assessment and failed to accurately asses the PU on three occasions. Findings include:</p> <p>Review of the clinical record for R 139 revealed;</p> <p>R139 was admitted on 3/18/15 with a stage III PU to the right ankle.</p> <p>4/1/15 - care plan for impairment of skin Integrly included the approach to document the wounds length, width, depth, appearance, amount and type of drainage weekly.</p> <p>8/6, 9/2, 9/9/15 - review of the weekly wound assessments incorrectly documented the right ankle PU as a stage II not a stage III (PU wounds do not become a lesser stage when healing).</p> <p>9/30 - 10/12/15 - there was no evidence in the clinical record that a weekly assessment was conducted.</p> <p>11/19/15 10:12 AM - Interview with E15 (RN, UM) confirmed that the PU should not have been reversed staged and that there was a weekly wound assessment missing.</p>	<p>F 314</p> <p>System Changes</p> <p>Success Evaluation</p> <p>Individual/ Resident Impacted</p>	<p><b>F309 - Continued</b></p> <p>R136 was not positioned properly during meals as per physician order. The root cause for this deficient practice is an identified weakness in the facility process for communicating restorative/rehab dining plans to CNAs.</p> <p>A. Staff Development to provide in-service to all nursing staff on Aspiration Precautions and proper positioning during meals by 1/8/16 (Attachment 24).</p> <p>B. The restorative task team will review and revise rehab dining care plans. A copy of the Resident's Dining Plan will be placed in the CNA books and Nutrition Data Record for Staff's quick reference.</p> <p>C. Registered Dietitian, Nursing supervisors and Nurse Managers will be conducting random meal observation rounds to ensure proper positioning during meals (Attachment #17).</p> <p>Individuals responsible for Action: Registered Dietitian, Nursing Supervisors and Nurse Managers will conduct random meal observation rounds weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three consecutive evaluations. Finally, we will conduct meal observations one month later. If the facility is still in compliance, then we will conclude that we have successfully addressed the deficient practice. Findings from Dining Observations rounds will be forward to facility QAPI team for evaluation and discussion at quarterly QAPI meetings. The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>F314 – Treatment/Svcs To Prevent/Heal Pressure Sores</b></p> <p>The pressure ulcer which was incorrectly staged as a stage II on the MDS assessment was corrected on 11/26/15 to reflect R139's current health status. The MDS assessment was corrected on 11/26/15. The Registered Nurse responsible for the error was in-serviced on Section M – Skin conditions on the MDS 3.0 on 12/12/15 (Attachment #18).</p>	01/08/16



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F 315	<p>Continued From page 24</p> <p>6/17/15 nursing note at 6:30 AM - resident did not void until offered the urinal, took urinal and voided.</p> <p>6/19/15 nursing note at 4:00 AM - able to verbalize when needed to use the urinal.</p> <p>6/21/15 nursing note at 6:50 AM - offered urinal twice when awake, attempted to use but resident already going before urinal in place.</p> <p>6/22/15 admission MDS - documented R146 required limited assistance of one person for bed mobility; limited assistance of two persons for transfer; totally dependent for toileting; had a trial of a urinary toileting program; was frequently incontinent of urine; and scored 6 out of 15 on the BIMS indicating severe cognitive impairment.</p> <p>Review of June 23 - June 27, 2015 trial toilet schedule documentation every 2 hours showed R146 was dry 14 times, incontinent 15 times and urinated 4 times.</p> <p>6/29/15 care plan problem for bowel and/or bladder toileting included interventions: toilet resident every 2 hours while awake; offer bedpan/urinal every 3 hours during the night or assist to bathroom and document how you found the resident and the result of the toileting.</p> <p>7/1/15 Resident Care Meeting Summary - documented R146 was "starting to use the urinal".</p> <p>July 1 - 21, 2015 CNA toileting program documentation included: promote continence, use reminders, orient resident to toileting time</p>	F 315	<p><b>F314 - Continued</b> These evaluations will continue weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct monthly audits until we reach 100% success at three consecutive evaluations. If the Facility is still in compliance, then we will conclude that we have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>F315 - No Catheter, Prevent UTI, Restore Bladder</b></p> <p>This was an isolated incident and not a facility practice. R164 had a new assessment of his continence status including a toileting program from 12/11/5 to 12/17/15.</p> <p>All residents have the potential to be affected by the deficient practice that the facility failed to assess and provide appropriate treatment and services to restore as much normal bladder function as possible. The facility will embark on a Nursing Restorative Program that will identify residents who exhibit incontinence of bowel or bladder or residents at risk for developing incontinence. These residents are assessed, and provided with individualized treatments and services. All residents will be assessed by a nurse on admission and as needed, for appropriateness of bladder retraining or for determining toileting plan potential. If indicated upon assessment, a trial toileting program will be implemented for three days to determine the appropriateness of continuing, revising, or discontinuing the plan. A sweep of all incontinent residents' charts was conducted on 12/08/15. The Unit Managers and RNAC reviewed all recent MDS's to identify and document continence status and make any necessary changes.</p>		

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F 315	<p>Continued From page 25 and place, provide privacy and time to urinate. Review of this documentation showed, between July 9 - 17, out of nine (9) night shifts when the resident was toileted, he remained dry on five (5) shifts.</p> <p>7/17/15 nurses' note - documented resident moved to Candee 3 at 1:30 PM.</p> <p>July 17 - 21, 2015 CNA toileting program documentation showed no evidence that toileting (urinal) was offered to R146 after the transfer to Candee 3.</p> <p>7/21/15 care plan problem initiated for altered elimination related to incontinence and inability to use toilet included the intervention to check for incontinence and turn/reposition every 2 hours (check and change every 2 hours).</p> <p>9/10/15 quarterly MDS - R146's assistance needed for bed mobility, transfer and toileting was unchanged from the previous assessment; had no trial of a urinary toileting program; was always incontinent of urine; and scored 1 out of 15 on the BIMS showing further decline in cognition from admission assessment.</p> <p>10/13/15 Resident Profile in the CNA documentation binder included the addition that resident was able to walk a short distance with walker with assist of two staff.</p> <p>11/20/15 review of the resident's record found no evidence an assessment was completed or a nurses' note written to indicate the reason for the removal of measures to promote continence and to place R146 on a check and change schedule every 2 hours.</p>	F 315  System Changes          Success Evaluation	<p><b>F315 - Continued</b></p> <p>The root cause for the inaccurate assessment is knowledge deficit and failure to review the Nursing Assistant documentation prior to completing the MDS, and a weak process for unit to unit transfers to address this deficiency the facility will take the following measures:</p> <p>A. Complete refresher training for all Unit Managers or designee on MDS coding of Section (H) bowel and bladder.</p> <p>B. Unit managers, supervisors or designee will review continence documentation, post assessment of void/bowel pattern and determine the plan of care.</p> <p>C. Restorative team to monitor documentation every month and make recommendations for current toileting program.</p> <p>D. At the end of each Inter-Disciplinary Team Meeting the care plan will be updated to reflect resident's current level of continence.</p> <p>E. A list of each resident on a Bowel and Bladder program will be maintained to identify each resident on toileting program.</p> <p>F. The Unit Managers and the RNAC will meet weekly to review each completed MDS to ensure coding accuracy.</p> <p>G. The RNAC will review the MDS's one more time for coding accuracy prior to submission.</p> <p>Individuals responsible for Action: Nursing Supervisors will conduct random audits of completed MDS's to ensure coding accuracy. The restorative team will audit the Bowel and Bladder documentation for every resident identified as incontinent. Completed MDS's and Bowel and Bladder documentation will be evaluated for accuracy weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated one more time. The facility will measure practices one month later. If the facility is still in compliance, then they will conclude that they have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI's team role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p>	01/08/16

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F 315	<p>Continued From page 26</p> <p>11/20/15 review of facility policy entitled Bowel and Bladder Program (revised 6/30/15) included: - initiate a 3-day voiding log or trial toileting schedule upon admission to assess the resident's voiding status/pattern. - with a significant change in the resident's condition complete a urinary continence assessment to determine if the resident may benefit from a toileting program. - If, at any time, it is determined that continence cannot be improved or maintained, staff will use a check and change strategy. - toileting plan (prompted voiding/scheduled voiding) consists of toileting the resident every 2 hours during waking hours and every 3 hours during the night. Document results of toileting - nurse will evaluate and document effectiveness of the program in the nurses' notes after completion of a 3-day trial. If the plan is unsuccessful, all steps taken, any revisions, and reasons for ineffectiveness will also be documented.</p> <p>11/24/15 at 9:25 AM during an interview with E4 (UM), E4 could not explain the lack of documented assessment prior to changing the resident to a check and change status. E4 asked E13 (LPN) as to reason that voiding was not documented after the transfer to Candee 3. E13 stated that R146 was in bed a lot initially and was incontinent by the time the urinal was offered but offered no other reason.</p> <p>The facility failed to complete and document an assessment to determine that continence could not be improved / maintained prior to switching R146 to a check and change strategy and removing strategies to maintain / improve</p>	F 315			

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F 315	Continued From page 27 continence.	F 315	<b>F323 – Free Of Accident Hazards/Supervision/Devices</b>  R37's upper side rail closest to the door was immediately repaired by maintenance on 11/16/15. A metal wrench used by maintenance to make the repair was returned to maintenance on 11/18/15.	01/08/16
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the resident environment remained as free from accident hazards as possible for 1 (R73) out of 26 sampled residents. R73's side rail was loose creating enough space for the resident's head to get caught between the mattress and the side rail. Findings include:  Review of R73's clinical record revealed;  R73 was admitted 4/7/09 with Alzheimer's Disease and was unaware of safety precautions.  3/11/12 last reviewed 10/8/15 - care plan problem for potential for falls included the following interventions; 1/4 side rail as mobility aid; notify nurse if device missing or broken.  10/21/15 - resident profile in the CNA	F 323		
		Individual/ Resident Impacted		
		Identification of other residents with the potential to be affected	All resident who have beds with side rails (ordered by their physician) have the potential for this deficiency. A sweep of all beds with side rails currently in use was conducted and corrective actions were made on 11/25/15 and repeated on 12/15/15.	
		System Changes	The QAPI Steering Committee has determined that a bed safety screening audit will occur quarterly. (Attachment 20). Adaptive Equipment, Quality Assurance Risk Manager/Safety Officer and RN Unit Managers will conduct monthly side rail inspections to ensure that all side rails remain free from accident hazards and do not move away from the mattress. The inspections will be logged by Adaptive Equipment. Copies of the logs will be sent to each Nursing Unit and to Quality Assurance.	
		Success Evaluation	The Quality Assurance Department and the Adaptive Equipment Department will review the side rail inspection logs each month to ensure 100% compliance and will report the results of these inspections at the month Safety Committee meetings. Quality Assurance will randomly audit the inspection logs once a month (by inspecting randomly selected side rails) for three months to determine if the inspection process is working properly and maintaining compliance. Quality Assurance will present its findings and recommendations monthly to the Director of Nursing and Facility Director; and, will include their findings in their quarterly reports to the QAPI Committee. In addition, Adaptive Equipment and Staff Development will conduct training for Nursing staff on how to inspect and adjust side rails during their normal daily rounds by 01/08/16.	

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F 323	Continued From page 28 documentation binder included that R73 ambulated independently with a wheeled walker.  11/16/15 at 10:45 AM observation - the upper side rail closest to door was extremely loose with 3 - 4 inches of motion away from the mattress, creating a gap over 5 inches between the mattress and the side rail. The upper side rail nearest the wall had 1/2 - 1 inch movement.  11/16/15 at 11:10 AM interview with E10 (LPN) verified that side rails usually do not move away from the mattress. The nurse checked the side rails and asked the secretary to contact maintenance for immediate repair.  11/18/15 at 10:20 AM observation - side rails no longer loose but a metal wrench, around 9 inches in length was found on the floor under R73's bed. The wrench was returned to maintenance.  These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329			

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F 329	<p>Continued From page 29</p> <p>who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview It was determined that for one (R139) out of 26 sampled residents the facility failed to ensure adequate indication for use and monitoring of psychoactive medications. R139 was on medication to treat anxiety and Bipolar disorder but was not being monitored for the symptoms that the medication was treating. Findings include:</p> <p>Review of the clinical record for R139 revealed;</p> <p>3/18/15 - R139 was admitted to the facility. Admission physician orders documented the use of an anti-anxiety medication three times a day, an anti-depressant medication daily and an antipsychotic medication to treat Bipolar symptoms twice a day.</p> <p>5/5/15 - Care plan for alteration in emotional status: depression. Review of the care plan lacked evidence of approaches related to anxiety or Bipolar symptoms.</p>	F 329	<p><b>F329 – Drug Regimen Is Free From Unnecessary Drugs</b></p> <p>R139's care plan was updated on 11/26/15 to include non-pharmacological interventions related to anxiety and bipolar symptoms. Behavior intervention monitoring flow record was updated to accurately monitor behaviors related to signs and symptoms of anxiety and bipolar disorder.</p> <p>All residents have the potential to be affected by the deficient practice. A list of all residents on psychoactive medication was reviewed for appropriate use, evaluation and monitoring on 12/09/15 using a new QAPI audit tool that is attached. (Attachment # 21)</p> <p>The root cause for inaccurate documentation is related to a knowledge deficit and failure to appropriately identify resident's behavior symptoms. Corrective action will be taken as needed through the use of the Behavioral CAAs. The facility will take the following measures to ensure accurate documentation and behavior monitoring.</p> <ol style="list-style-type: none"> <li>1. All Licensed Staff will receive training on behavior monitoring and appropriate care planning interventions and approaches by the Trainer Educator III.</li> <li>2. All Licensed Staff and CNAs will be in-serviced on identifying resident's behavior symptoms, documenting the behavior on the behavior monitoring sheet and nursing assistant documentation record.</li> <li>3. At each Inter-Disciplinary Team meeting the team will review resident's current psychoactive medications and plan of care. This will ensure that residents are care planned appropriately for the use of psychoactive medications, with diagnosis and interventions.</li> <li>4. Quarterly GDR meetings will be held with the Pharmacist, Medical Director and Director of Nursing.</li> </ol>	01/08/16

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F 329	<p>Continued From page 30</p> <p>11/2015 - Behavior Intervention Monitoring Flow Record being was used to document the behaviors of physically abusive and abusive gestures.</p> <p>11/19/15 at 2:54 PM - Interview with E21 (CNA) about how the resident's anxiety revealed that when others cannot understand his communication he can become frustrated. He may also get anxious if he runs out of cigarettes. She added that he "likes things done like yesterday".</p> <p>11/20/15 10:38 AM - Interview with E15 (RN, UM) revealed that she does not really see anxiety with R139 except when he cannot communicate. She added that the psychoactive medication that he receives came with him when he was admitted from the hospital. E15 added that she did not really know why he was on them and the facility had not tried to change them. E15 revealed that she had not seen him display the physical behaviors that are being monitored.</p> <p>11/24/15 - Review of the facility's policy for Psychoactive Medications approved on 5/20/15 documented the following; *goal - determining the underlying cause of behavior symptoms so the appropriate treatment of environmental, medical and/or behavioral interventions, as well as psychopharmacological medications, can be utilized to meet the needs of the individual resident. *standard - physician will use psychotropic / psychoactive medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring and psychoactive drugs require both behavior and side effect monitoring.</p>	F 329  Success Evaluation	<p><b>F329 - Continued</b></p> <p>Nursing Supervisors, Unit Managers or designees will conduct random audits of psychoactive medication use and documentation. Audits will include physician order sheets related to the use of psychoactive drugs and diagnosis. Completed audits will be evaluated for accurate documentation and for care plan updates. This will continue weekly for 12 weeks, or until the facility reaches 100% success over 10 consecutive evaluations. They will then conduct a bi-weekly audit until they reach 100% success at three consecutive evaluations. They will measure practices one month later. If facility is still compliant, then they will conclude that they have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality assurance Committee meetings (QAPI).</p>	

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F 329	Continued From page 31	F 329	<p><b>F371 – Food Procure, Store/Prepare/Serve – Sanitary</b></p> <p>The facility failed to serve food under sanitary conditions on one (Candee 3) out of five dining rooms.</p> <p>One 11/25/15 Director of Nursing met with Nurse Managers to review survey findings. Director of Nursing instructed Nurse Managers to remind their staff on the principles of proper handwashing and glove usage during meals.</p> <p>All residents have the potential to be affected by this deficient practice. The Dietitian will conduct daily inspections of breakfast, lunch and dinner meals on a rotating basis for all five Candee Nursing Units to ensure that staff maintain proper handwashing and glove usage during meals.</p> <p>Resident R146 was served a sandwich that was touched by contaminated gloves. The root cause for the deficient practice was staff failure to implement proper handwashing. The facility will take the following measures to ensure staff understanding of hand washing and proper glove usage:</p> <p>A. Staff Development will in-service all nursing staff by 1/8/16 on proper glove usage, handwashing and meal service (Attachment 25).</p> <p>B. The sanitary Meal Service In-Service will be given to nursing staff annually from this point forward.</p> <p>C. Registered Dietitian, Food Service Director, Nursing Supervisors and Unit Managers will make weekly random meal observation rounds (Attachment #17).</p> <p>Individuals responsible for Action: Registered Dietitian, Food Service Director, Nursing Supervisors and Unit Managers will conduct random meal observation audits weekly for 12 weeks or until the facility reaches 100% success over 10 consecutive evaluations. We will then conduct bi-weekly meal observation audits until we reach 100% success at three consecutive evaluations. Finally, we will conduct meal observation audits one month later.</p>	01/08/16
F 371 SS=D	<p>83.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation it was determined that the facility failed to serve food under sanitary conditions on one (Candee 3) of 5 dining rooms. Findings include:</p> <p>Observation made on Candee 3 on 11/16/15 from 12:10 PM to 12:25 PM - While wearing gloves, E14 (CNA) removed R146's meal tray from the cart, removed lids from several cups and poured gravy onto food. Then, while unwrapping R146's sandwich, E14 touched it with the now contaminated gloves.</p> <p>If ready-to-eat food cannot be removed from wrapping without touching, employee must wear</p>	<p>Individual/ Resident Impacted</p> <p>F 371</p> <p>Identification of other residents with the potential to be affected</p> <p>System Changes</p> <p>Success Evaluation</p>		

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F 371	Continued From page 32 clean gloves.	F 371	<b>F371 - Continued</b> If the facility is still in compliance, then we will conclude that we have successfully addressed the deficient practice. Findings from dining Observations will be forwarded to facility QAPI team for evaluation and discussion at quarterly QAPI meetings. The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  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 hand washing is indicated by accepted professional practice.  (c) Linens	F 441  <b>Individual/Resident Impacted</b>  <b>Identification of other residents with the potential to be affected</b>  <b>System Changes</b>  <b>Success Evaluation</b>	<b>F441 - Infection Control, Prevent Spread, Linens</b>  A policy and procedure task committee has been established to review current infection control program to include updating and deleting outdated policies and procedures.  All residents have the potential to be affected by the deficient practice. The facility will complete an initial review and update of the LTC Section's infection control policies. Outdated policies will be archived and policies will include current references by 01/08/16.  The infection prevention and control committee will review the infection control manual periodically and implement current recommendations regarding infection prevention control practices. The Infection Preventionist will attend APIC (Association for Professional in Infection Control and Epidemiology) meetings and seminars related to infection prevention and control practices. The facility Quality Assurance Committee will review infection control trend reports and corrective actions at least quarterly to assure that appropriate corrective action has occurred.  The Infection Preventionist in collaboration with Staff Development will be responsible for ensuring that the infection control manual will be reviewed and revised to maintain current practices for 100% compliance per State, Federal and CDC guidelines.	01/08/16

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

PRINTED: 12/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/24/2015
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 441	<p>Continued From page 33</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview it was determined that the facility failed to maintain and update policies and references related to the infection control program. Findings include:</p> <p>September 2014 - CDC recommended adding the PCV13 [Pneumovax 13-pneumococcal conjugate vaccine an additional protection against pneumonia for all adults over 65]-in the series with the PPSV23 [pneumococcal polysaccharide vaccine protects against 23 types of pneumonia] for adults aged 65 and older. PCV13 was also approved for use in persons aged 50 years and older.</p> <p>Review of facility documents revealed:</p> <p>11/23/15 at 3:00 PM review of two binders containing the infection control program policies and other reference materials found:</p> <ul style="list-style-type: none"> <li>- 22 policies with revision dates ranging from 10/6/04 to 5/15/08. There was no evidence that the policies were reviewed since the revision date.</li> <li>- Influenza and pneumonia vaccinations policy (revised 5/2012) did not include the addition of the PCV13 even though record review found the facility administered this vaccine (PCV13) to residents last month.</li> <li>- CDC document entitled Guideline for Prevention</li> </ul>	F 441			

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F 441	<p>Continued From page 34 of Catheter-Associated Urinary Tract Infections was undated but included references from 1956 through 1980. The current edition of this document on the CDC website was dated 2009 which was not the one in the facility binder.</p> <p>Review of the monthly infection logs covering June through October 2015 found: - One resident was on transmission-based precautions. - Each month from June through September there was at least one UTI on Candee 5 with bacteria called Klebsiella. In August, 2015 Candee 5 had three residents with a UTI due this specific bacteria.</p> <p>11/24/15 interview at 9:45 AM with E14 (Infection Control) revealed: - E14 had been the recruiter and was given oversight of the infection control and employee health programs earlier this year. - E14 monitored the infections within the facility and produced a monthly infection log by unit. E14 reviewed resident records and infection worksheet, verified the antibiotic order and looked at laboratory results. E14 stated that she and the physician would confirm the ordered antibiotic was appropriate for the specific bacteria. - E14 said one unit had several UTI's with same organism and that she would be performing hand hygiene audits and providing hand hygiene education with the staff. E14 stated that staff educators would refuse to assist in providing infection control specific education indicating it was E14's job to do so. - E14 was unsure how often policies were reviewed but thought that the infection control policies were next up for review. E14 confirmed the policies and references were outdated and</p>	F 441	<p><b>F514 – Res records- Complete/Accurate/Accessible</b></p> <p><b>Item 1</b> R131's medication administration record was updated on 11/20/15 to reflect current physician orders for medication administration. Immediate staff awareness and re-education was provided by Nurse Managers regarding the need for accurate and completion of documentation.</p> <p><b>Item 2</b> R146's documentation omissions were reviewed by facility leadership. Immediate staff awareness and re-education was provided by Nurse Managers regarding the need for accurate and completion of documentation.</p>	

Individual/  
Resident  
Impacted

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NAME OF PROVIDER OR SUPPLIER  <b>DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHC)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SUNNYSIDE ROAD SMYRNA, DE 19977</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)	(X6) COMPLETION DATE
F 441	Continued From page 35 stated that between getting the job in the past year, the turnover of staff and getting a new DON, E14 had not worked on it. "This is how I inherited it."  These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.	F 441	<b>F514 - Continued</b> <b>Item 1</b> All residents have the potential to be affected by this deficient practice. A sweep of all residents' physician orders and review of Medication Administration Records (MAR) was completed by 12/31/15. Physician orders that were reviewed were found to be accurate and documentation completed. Corrective action that will be taken to address the impact of the deficient practice on other residents will include awareness and refresher training, verbal counseling and progressive disciplinary action if necessary.	
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 observation, record review and interview it was determined that the facility failed to maintain accurate and complete clinical records for two (R131 and R146) out of 26 sampled residents. For R131 a physician order was not transcribed to the Physician Order Sheet (POS). For R146 toileting program documentation was not complete or accurate. Findings include:  1. 11/16/15- At 8:51 AM During a medication administration observation E20 (LPN) was	F 514  Identification of other residents with the potential to be affected  System Changes	<b>Item 2</b> All residents have the potential to be affected by this deficient practice. A sweep of all Certified Nursing Assistant documentation books was completed by 12/31/15. All CNA documentation books for the review period ending on 12/31/15 were reviewed and found no omissions. Corrective action that will be taken to address the impact of the deficient practice on other residents will include awareness and refresher training, verbal counseling and progressive disciplinary action if necessary.  <b>Item 1</b> The root cause for this deficient practice is the lack of a check and balance system for ongoing transcription and documentation. The facility will take the following measures: A. Complete refresher training for all nursing staff on expected documentation standards. B. Complete refresher training for all nursing staff regarding physician orders, medication administration and transcription by 1/8/16. C. A tracking tool has been developed for nursing to ensure that all new physician orders are transcribed accurately on the medication administration record and documented in the resident's clinical record (Attachment #22).  <b>Item 2</b> The root cause for this deficient practice is a lack of check and balance system for ongoing CNA documentation.	01/08/16

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NAME OF PROVIDER OR SUPPLIER  <b>DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SUNNYSIDE ROAD SMYRNA, DE 19977</b>		
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F 514	<p>Continued From page 36</p> <p>observed administering medications orally to R131. Upon surveyor review of the POS for R131, several of the medications administered during the observation were ordered to be administered by g-tube.</p> <p>During an interview on 11/19/15 at 2:36 PM, E19 (RN) reported that R131 had been receiving all medications orally since a physician order was written on 9/30/15. E19 confirmed that the order to administer all medications orally was not transcribed to the monthly POS.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 11/24/15 at 2:10 PM.</p> <p>2. Review of R146's toileting program documentation on the CNA assignment record between July 1 and July 17 2015 (while a resident on Candee 4) found 11 out of 49 shifts were blank with no documentation. Additionally there were 4 shifts (night shift on July 2, 3 and 4; evening shift on July 3) where the CNA wrote their initials instead of using the documentation code of D=dry; I=incontinent; V=vold.</p> <p>11/24/15 interview with E4 (UM) confirmed the 11 missing shifts and 4 inaccurate entries.</p> <p>These findings were reviewed with E1 and E2 on 11/24/15 at 2:10 PM.</p>	F 514	<p><b>F514 - Continued</b></p> <p>A. Complete refresher training for all nurses and CNA staff on expected documentation standards.</p> <p>B. Nurses will be assigned on each shift to complete a review of CNA documentation shift to shift to identify omissions.</p> <p>C. A tracking tool has been developed for nursing to ensure all documentation is completed accurately (Attachment #23).</p> <p><b>Item 1</b> Individuals responsible for Action: Unit Managers and/or designee will review the tracking tool weekly for three months or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated one more time. They will measure practices one month later. If the facility is still in compliance, then they will conclude that they have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p> <p><b>Item 2</b> Nursing Supervisors and Unit Managers or designee will review the tracking tool weekly for three months or until the facility reaches 100% success over 10 consecutive evaluations. The above audit process will be repeated one more time. They will measure practices one month later. If the facility is still in compliance, then they will conclude that they have successfully addressed the cited deficient practice. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI). The QAPI team's role is to meet at least quarterly and review root cause analysis, trends and corrective actions as appropriate.</p>		



**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:** Delaware Hospital for the Chronically Ill

**DATE SURVEY COMPLETED:** November 24, 2015

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><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 from November 16, 2015 through November 24, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 137 (one hundred thirty seven). The Stage 2 sample totaled 26 (twenty six) residents.</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: Cross Refer to the CMS 2567-L survey completed November 24, 2015</b> F252, F253, F258, F272, F278, F279, F280, F309, F314, F315, F323, F329, F371 F441 and F514.</p>	<p>3201.1.12</p> <p>Cross referenced CMS 2567-L Survey date completed November 24, 2015 F252, F253, F258, F272, F278, F279, F280, F309, F314, F315, F323, F329, F371, F441 and F514</p>	
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Provider's Signature  Title Hospital Director Date 1-26-16

DR RHA Lic: H10000588