

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

PRINTED: 08/21/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A011 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/04/2015 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER FIVE STAR FOULK MANOR NORTH LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1212 FOULK ROAD WILMINGTON, DE 19803 | | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from July 29, 2015 through August 4, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 30. The Stage 2 survey sample size was 24.</p> <p>Abbreviations/definitions in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FSD - Food Services Director; MD - Maintenance Director; PT - Physical Therapy/Therapist; Pt/pt - patient; OT - Occupational Therapy/Therapist; RDH - Regional Director of Health; SW-Social Worker; ADL - Activities of daily living/tasks needed for dally living, such as dressing, hygiene, eating, toileting, bathing; ROM - Range of Motion/extent to which a joint can be moved safely; Anxiety- general term for several disorders that cause nervousness, fear, apprehension and worrying; BLE - bilateral (both sides) lower extremities; BM- bowel movement;</p> | F 000 | <p>Responses to the cited deficiencies do not constitute an admission of agreement by Foulk Manor North of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.</p> | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Regina C. Gray Executive Director October 2, 2015

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 c - with; cm - centimeters; L/Lt - left; FYI - For Your Information; PRN - as needed; amt - amount; abx - antibiotic; LLE - left lower extremity; W/C - wheelchair; SPT - Stand, Pivot, Transfer; MD - Medical Doctor/physician; NP - Nurse Practitioner; ER - Emergency Room; TED/TEDs - anti-clot stockings; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; DARCO shoe - customized shoe that offers support and protection for the foot; Diabetes - disease where sugar levels are too high; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; Guard belt/gait belt/transfer belt - device used to transfer people from one position to another; Extensive assistance - resident involved in activity, staff provide weight-bearing support; Hoyer lift - apparatus used to transfer a person via a sling; Hospice - service that provides care to residents that are terminally ill; Lateral - side part of something; Sutures/stitches - surgical method used to close a wound or join tissues; Tactile-designed to be perceived by touch; Total dependence/totally dependent - full staff | F 000 | | |

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| F 000 | <p>Continued From page 2</p> <p>performance every time;</p> <p>Transfer - how resident moves between surfaces including to or from bed, chair, wheelchair, standing position;</p> <p>Hgb A1C - blood test that shows the average blood sugar level for the past 2-3 months;</p> <p>TAR - Treatment Administration Record;</p> <p>MDS-Minimum Data Set-Standardized assessment form used in nursing homes;</p> <p>Eval - evaluation;</p> <p>Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions;</p> <p>MAR- Medication Administration Record;</p> <p>MRR- Monthly Regimen Review;</p> <p>NN - Nurses' notes;</p> <p>PVD - Peripheral Vascular Disease/disease of blood vessels (arteries) caused by build-up of fatty material within the vessels; gradual process in which the artery becomes blocked, narrowed, or weakened;</p> <p>POS-physician order sheet;</p> <p>Sliding board/transfer board - wooden or plastic board used to transfer into and out of a wheelchair;</p> <p>UA-Urinalysis - diagnostic test used to detect and assess a disease or illness OR diagnostic test used to determine presence of infection;</p> <p>Incontinence - loss of control of bladder &/or bowel function;</p> <p>Frequently incontinent- 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period;</p> <p>Urinary bladder-organ that collects urine;</p> <p>Urinary continence- ability to prevent accidental leakage of urine from bladder;</p> <p>Void - to urinate, empty one's bladder;</p> <p>C&S-Urine culture and sensitivity - a microscopic</p> | F 000 | | |

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| F 000 | Continued From page 3 study of the urine culture performed to determine the presence of pathogenic bacteria in patients with suspected urinary tract infection; UTI-Urinary Tract Infection - bacteria in urine; E. coli-Escherichia coli, a type of bacteria commonly found in the gastrointestinal (GI) tract; Straight Catheter (straight cath) - a tube-shaped medical device used to remove urine from a person's bladder; AIMS-The Abnormal Involuntary Movement Scale- a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; Psychotic drug- chemical substance that changes brain function and results in alteration in mood; BIMS score - Brief Interview of Mental Status used to aid to detecting cognitive impairment/dementia; Cognition - mental processes; thinking; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Posterior - further back in position; Nebulizer - an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Nebulizer Treatment- changes liquid medication into fine mist to breathe directly into lungs; Pneumococcal - germs called pneumococcus that may cause a lung infection. | F 000 | | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS | F 225 | | | |

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| F 225 | Continued From page 4 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: | F 225 | 1. A self-report was submitted for R14 on 7/27/2015. The incident was investigated. R14 remains stable and safe in the facility. The Regional Director of Health and Wellness in-serviced the Director of Nursing and clinical leadership team on proper guidelines regarding state agency reporting requirements. 2. All residents have the potential to be affected by this deficient practice. Audits past sixty (60) days to identify state reportable incidents which were not submitted in accordance with state regulations. 3. The root cause analysis of this practice revealed that there was confusion regarding when to report a skin tear of unknown origin. All nursing supervisors will contact the Director of Nursing or Clinical Leadership Team of an | 10/2/2015 | |

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| F 225 | <p>Continued From page 5</p> <p>Based on record review, interview, and review of facility documents, it was determined that the facility failed to immediately report an injury of unknown source to the State agency according to State law that had the potential for abuse for one (R14) out of 24 Stage 2 sampled residents. Findings include:</p> <p>Cross refer to F323, example #1 An annual MDS assessment, dated 7/27/15, stated R14's daily decision making skills were severely impaired and she was totally dependent on two (2) staff for transfers.</p> <p>A nurse's note, dated 7/27/15 and timed 5:00 PM stated, "At 1540 (3:40 PM) I was called in to the resident's room and found resident sitting on her bed with a skin tear on left lower extremity...measuring 8 cm x (by) 10 cm. Resident does not recall how she got the skin tear...Called Dr. (name)...ordered PT/OT eval and 2 person assist for all transfers..."</p> <p>The facility Incident Report Form, dated 7/27/15, stated a skin tear measuring 8 x 10 cm was noted on R14's LLE and the resident does not recall what happened.</p> <p>A statement included in the facility's investigation, dated 7/27/15 and timed 5:00 PM, stated "...asked CNA (name) if it was possible if this injury could have occurred while she was transferring the resident from w/c to bed...CNA (name) agreed and said, 'I could have done it when I transferred her to the bed...'. "</p> <p>Although the facility began an investigation, they failed to recognize this as having the potential for neglect of care and they failed to report it within</p> | F 225 | <p>occurring incident, to ensure proper state agency reporting. All licensed staff will be in-serviced on reportable incidents, annually and upon new hire orientation.</p> <p>4. The Director of Nursing or designee will conduct a daily audit of incident reports for compliance with identified reporting requirements in the clinical morning meeting. An audit of all state reportable incidents will be conducted every week times four (4) weeks until 100% compliant and then every two (2) weeks times two (2) months, until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> | |

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| F 225 | Continued From page 6 eight (8) hours to the State Agency, as required by State regulations. The facility did not report it until 24 hours later. | F 225 | | |
| F 278 SS=D | Findings were reviewed with E2 (DON) and E14 (RDH) on 8/4/15 at approximately 11:40 AM. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. | F 278 | 1. The MDS was corrected for R1 on 8/3/2015, to accurately reflect R1's behavior/hygiene needs. 2. All residents have the potential to be affected by this deficient practice. The RNAC/designee will audit residents' most current MDS under the behavior/hygiene and functional status section, to determine accuracy. All inaccuracies will have a correction MDS submitted to define their accurate behavior and hygiene status. 3. The root cause analysis determined that the MDS inaccuracies were due to data entry error. The RNAC/Social Services will be in-serviced by the | 10/2/2015 |

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| F 278 | <p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility's MDS assessments for 1 (R1) out of 24 Stage 2 sampled residents reviewed did not accurately reflect the resident's status. The facility failed to include R1's behavior and accurately code her personal hygiene needs on her quarterly assessment. Findings include:</p> <p>The quarterly MDS assessment, dated 6/9/15, stated R1 did not exhibit any behaviors during the seven (7) day MDS look back period (6/3/15 to 6/9/15). The same MDS also stated that for R1 personal hygiene did not occur, coded as 8,8.</p> <p>Review of Nurse Notes revealed the following: -6/5/15 at 9:40 PM: ..."Resident refused to (sic) straight cath this PM. Resident was yelling and fighting during the procedure..."</p> <p>-6/6/15 at 8:45 PM: "Resident became combative when this nurse attempted to straight cath her; stating 'Stop that right now'..."</p> <p>-6/7/15 at 6:00 AM: ..."Resident refused straight cath saying 'never', yelling, and combative..."</p> <p>-6/8/15 at 10:00 AM: ..."Resident resistant to care this am... refusing care to CNA (sic) this am..."</p> <p>Review of a quarterly Social Service Progress note, dated 6/9/15, stated, "... at times can be resistant to care during her straight cath procedures..."</p> <p>Review of the Resident Monthly Personal Care Record for June 2015 lacked evidence to support</p> | F 278 | <p>Corporate MDS Director on appropriate documentation of behavior and hygiene status entries , times one (1) and as needed..</p> <p>4. The Director of Nursing will randomly audit 10% of all MDS's weekly times four (4) weeks until 100% compliant, every two (2) weeks times two (2) months until 100% compliant, then monthly. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> | |

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| F 278 | <p>Continued From page 8</p> <p>lack of personal hygiene for R1 in the seven (7) day MDS look back period.</p> <p>On 8/3/15 at 4:09 PM, E15 (RNAC) was interviewed. E15 confirmed that personal hygiene should have been coded for R1 as 2,2 (limited assistance, one person physical assist), instead of 8,8.</p> <p>On 8/3/15 at 4:19 PM: E15 completed the correction form for personal hygiene.</p> <p>On 8/3/15 at 4:40 PM, E9 (SW) was interviewed. Upon review of the Nurse Notes and the Social Service note, E9 confirmed that R1 was coded incorrectly for behavior.</p> <p>On 8/3/15 at approximately 4:50 PM, E9 completed the correction form for behavior. The corrected Behavior section stated R1 exhibited physical behaviors directed toward others (1) to (3) days, verbal behaviors directed toward others (1) to (3) days, and R1 rejected evaluation or care (4) to (6) days of the seven (7) day look back period.</p> <p>The facility's assessment failed to accurately reflect R1's status on the Quarterly MDS dated 6/9/15 under the Behavior section and the Functional Status section.</p> | F 278 | | |
| F 280 SS=D | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged</p> | F 280 | | |

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| F 280 | <p>Continued From page 9</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise care plans for 2 (R6 and R30) out of 24 stage 2 sampled residents. The facility failed to revise care plans to include interventions to do AIMS testing upon admission and at least every 6 months thereafter as per pharmacy recommendations for R6 and R30. Findings include:</p> <p>1. R30 was admitted to the facility on 3/4/14. R30's admission MDS, dated 3/5/15, indicated he was receiving antipsychotic medication. An AIMS assessment was completed on 3/4/14.</p> | F 280 | <ol style="list-style-type: none"> R6 remains in the facility and his/her condition is stable. The care plan has been updated to include baseline AIMS. All new residents have the potential to be affected by this deficient practice. All new residents receiving antipsychotic medications will receive a baseline AIMS upon admission. The root cause analysis revealed that the unit managers were unaware of the AIMS testing protocol. The Regional Director of Health and Wellness will in-service the RNAC and Director of Nursing, times one (1) and as needed, on the policy of baseline AIMS testing upon admission. The Director of Nursing /designee will audit all new admissions with prescribed antipsychotic medications and residents with newly prescribed antipsychotic medications for baseline AIMS times four (4) weeks until 100% compliant, every two (2) weeks for two (2) months until 100% compliant, then quarterly. | 10/2/2015 |

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| F 280 | <p>Continued From page 10</p> <p>Review of R30's care plan for being at risk for adverse effects related to receiving antipsychotic medication, dated 3/5/15 lacked an intervention to do an AIMS assessment every 6 months.</p> <p>A consultation report by the consultant pharmacist, dated 10/9/14, stated, "... an AIMS... assessment is not documented in the resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... at least every six months thereafter (or per facility protocol)...". The facility performed an AIMS assessment on 10/13/14; 39 days after it was due (due 9/4/14).</p> <p>A consultation report by the consultant pharmacist, dated 5/5/15, stated, an AIMS... assessment is not documented in the resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... at least every six months thereafter (or per facility protocol)...". The facility performed an AIMS assessment on 5/5/15; 22 days after it was due (due 4/13/15).</p> <p>Despite pharmacy recommendations on 10/9/14 and 5/5/15, the facility failed to revise R30's care plan to include an intervention to perform AIMS assessments at least every 6 months.</p> <p>2. R6 was admitted to the facility on 4/10/15. Medications for R6 on admission included antipsychotic medication.</p> <p>The facility initiated an undated admission care plan for use of psychotropic medications (includes antipsychotics). The rest of the admission care plan was dated 4/10/15. The psychotropic medication care plan was preprinted</p> | F 280 | <ol style="list-style-type: none"> 1. R30 remains in the facility and his/her condition is stable. The care plans have been updated to include AIMS tests every six (6) months. 2. All residents receiving anti-psychotic medications are at risk for this deficient practice. Care plans will be updated every six (6) months, to include AIMS tests, for residents who receive antipsychotic medications. 3. The root cause analysis revealed that the unit managers were unaware of the AIMS testing protocol and the RNAC did not list the AIMS testing in the interventions of care plan. The RNAC will include AIMS testing every six (6) months for all residents receiving anti-psychotic medications and review care plans, quarterly, to ensure timely AIMS testing. The Regional Director of Health and Wellness will in-service the RNAC, times one (1) and as needed, on the policy of care planning individual residents' needs. The Staff Development Coordinator will in-service all licensed staff, on the revision of care plans and with | |

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| F 280 | <p>Continued From page 11 and listed an intervention for "... Complete a baseline AIMS test if I'm on antipsychotic medication and per policy thereafter...", however, this was not checked to be done for R6.</p> <p>On R6's admission MDS assessment, dated 4/16/15, he was identified as being on an antipsychotic.</p> <p>During the MRR on 5/6/15 the consultant pharmacist identified lack of a baseline AIMS for R6 and notified the facility. The consultation report by the pharmacist, dated 5/6/15, stated, "... an AIMS... assessment is not documented in the resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... now and then at least every six months thereafter (or per facility protocol)...".</p> <p>Record review revealed that an AIMS was completed for R6 by the facility on 5/6/15 (26 days after admission).</p> <p>Review of R6's permanent care plan for psychotropic drug use, dated 4/16/15, continued to lack an intervention for AIMS testing despite the pharmacist's recommendations on 5/6/15.</p> <p>During an interview with E6 (UM) on 8/3/15 at 10:17 AM, E6 stated that the facility does not have a policy for AIMS assessments (in contrast to the above mentioned intervention on the admission MDS), they do them based on pharmacy recommendations.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 8/4/15 at approximately 4:45 PM.</p> | F 280 | <p>the development of interventions to address the AIMS scale. Training will be provided annually and upon new hire orientation.</p> <p>4. The Director of Nursing /designee will audit all residents receiving antipsychotic medications and determine which quarterly assessments are due for care planning and completion of AIMS testing times four(4) weeks, until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> | |

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| F 309 F 309 SS=E | <p>Continued From page 12 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interview, it was determined that for two (R31 and R50) out of 24 Stage 2 sampled residents, the facility failed to provide care and services to attain or maintain the highest practicable physical well-being in accordance with the plan of care. For R31, the facility failed to obtain and follow the 12/1/14 physician's order for a DARCO shoe, which continued for approximately nine months. For R50, the facility failed to follow a 4/17/15 physician's order for a Hgb A1C blood test in 3 months. Findings include:</p> <p>1. R31 was admitted to the facility on 9/8/14 and started hospice services on 9/10/14.</p> <p>A physician's order, dated 12/1/14, stated to obtain a DARCO shoe for the left foot.</p> <p>R31 was care planned for potential for falls with an intervention added on 12/2/14 that included the DARCO shoe to the left foot.</p> <p>A nurse's note, dated 12/18/14, stated that hospice called the facility about the DARCO shoe</p> | F 309 F 309 | <ol style="list-style-type: none"> R31 remains in the facility with no adverse effects from this deficient practice. The residents need for DARCO Boots was re-evaluated by the physician and subsequently discontinued. Any resident with an order for DARCO Boots have the potential to be affected by this deficient practice. All resident records have been audited for orders of DARCO Boots and any resident with such order will be identified and DARCO Boots will be obtained. The root cause analysis revealed there was a question about where to obtain and how to purchase the DARCO Boot. The Director of Nursing will review all new orders to identify orders for DARCO Boots. Once the order has been identified, the Director of Nursing will coordinate the ordering of said boots, to ensure delivery to the resident. The Regional Director of Health and Wellness will in-service the Director of Nursing/designee, regarding | 10/2/2015 |

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| F 309 | <p>Continued From page 13 and they would order it as it was covered by hospice services.</p> <p>A nurse's note, dated 1/12/15, stated the facility called hospice regarding the status of the DARCO shoe. Hospice stated that it would take another couple of weeks since they had to order it through an outside vendor.</p> <p>An observation on 7/31/15 at 10:52 AM revealed that R31 was wearing non-skid socks.</p> <p>An observation on 8/3/15 at 3:01 PM revealed that R31 was wearing non-skid socks.</p> <p>An observation on 8/4/15 at 11:20 AM revealed that R31 was wearing non-skid socks.</p> <p>Review of R31's clinical record lacked further attempts by the facility to obtain and follow-up on the 12/1/14 physician's order for a DARCO shoe for R31's left foot.</p> <p>In an interview on 8/4/15 at 11:24 AM, E16 (CNA) stated they were still waiting for R31's DARCO shoe to be delivered.</p> <p>In an interview on 8/4/15 at 11:39 AM, E6 (UM) stated there was some confusion as to who was going to obtain the DARCO shoe, whether it was hospice, the facility or R31's family, and what the specifications of the shoe were, as DARCO was a brand name. E6 stated the facility ordered the shoe and they were awaiting delivery. This surveyor asked for a copy of the order form for the DARCO shoe.</p> <p>In a follow-up interview on 8/4/15 at 1:52 PM, E6 was re-approached and asked the status of the</p> | F 309 | <p>equipment procurement times one (1) and as needed.</p> <p>4. The Director of Nursing/designee will audit all residents with DARCO Boot orders, weekly, times four (4) weeks until 100% compliant, monthly, times two (2) months until 100% compliant and quarterly, thereafter, to ensure procurement of said equipment. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> <p>1. R50 remains in the facility with no adverse effect related to this deficient practice. HGB/A1C was drawn on 8/4/2015.</p> <p>2. Any resident with an order to obtain a HgB A1C is at risk for being affected by this deficient practice. All residents with a HgB A1C order will be audited to ensure labs have been drawn.</p> | |

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| F 309 | Continued From page 14 DARCO shoe order form. E6 stated that E3 (ADON) was working on it. In a follow-up interview on 8/4/15 at 2:43 PM, E6 was asked if the facility ordered the DARCO shoe for R31, and E6 stated "no". The facility failed to provide care and services to meet the needs of R31 according to the plan of care by failing to obtain and follow the 12/1/14 physician's order for a DARCO shoe for R31's left foot, which continued for approximately nine months. 2. R50 was admitted to the facility on 11/28/12. A physician's order, dated 4/17/15, stated to obtain a Hgb A1C blood test in 3 months for a diagnosis of diabetes. Review of R50's July 2015 TAR revealed that Hgb A1C was signed off as "done" on 7/16/15. During an interview on 8/3/15 at 9:21 AM, E4 (UM) called the laboratory and confirmed that R50's Hgb A1C was not done. The facility failed to follow a physician's order, dated 4/17/15, for a Hgb A1C blood test for R50. | F 309 | 3. The root cause analysis revealed that there was a breakdown in the lab company's system and that the nurse inadvertently documented that the lab had been drawn. All residents who are receiving a HgB A1C every three (3) months, will be placed on a lab tracking form to ensure the labs will be drawn timely. Nursing/designee will review and verify that the labs have been drawn by using a lab tracking form. The Director of Nursing/designee will be in-serviced by the Regional Director of Health and Wellness, times one (1) and as needed, regarding the lab tracking form. 4. The Director of Nursing/designee will reconcile the lab tracking form verses the actual lab obtained to verify compliance with the physician's order. An audit of 10% of the lab tracking form, verses the actual lab obtained, will be conducted, weekly times two (2) weeks until 100% and then | |
| F 315 SS=D | Findings were reviewed with E1 (NHA) and E2 (DON) on 8/4/15 at approximately 4:45 PM. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an | | | |

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| F 315 | <p>Continued From page 15</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, it was determined that the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much bladder function as possible for one (R47) out of 24 Stage 2 sampled residents. The facility failed to accurately assess R47's urinary status upon admission, failed to fully complete a 3 day bladder flow sheet and failed to care plan accordingly based on the resident's individualized needs. As R47's urinary continence declined, the facility failed to comprehensively reassess and they again failed to care plan based on R47's individualized needs. Findings include:</p> <p>The facility's policy entitled, "Bladder Elimination Assessment", last revised 6/30/06, stated, ... Each resident will be assessed on admission to determine bladder continence or incontinence. If it is determined that the resident is incontinent an in-depth assessment will be completed using the Bladder Incontinence Evaluation Form.... A 3 day bowel and bladder flow sheet will be completed on each incontinent resident... The nurse will review the data from the Bladder Incontinence Assessment and the 3-day Bowel/Bladder Flow sheet to determine if the resident is a candidate for a re-training program... If the resident is not a</p> | F 315 | <p>monthly, times two (2) months, until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> <ol style="list-style-type: none"> 1. R47 is no longer in the facility. 2. Any resident incontinent of bladder is at risk for this deficient practice. All residents, who have been identified as incontinent, will have a three (3) day Bladder Diary initiated and completed. A Bladder Incontinence Assessment will be conducted and a care plan will be developed, based on the resident's individualized needs. 3. All new admissions and residents identified with a significant change with an increase in bladder incontinence will have a three (3) day Bladder Incontinence Diary conducted. Upon completion of the three (3) day Bladder Diary, a Bladder Incontinence Assessment will be conducted, if needed and an individualized | 10/2/2015 | |

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| F 315 | <p>Continued From page 16</p> <p>candidate for a re-training program, care planning for the resident should take into account the individual findings of the assessments. Re-assessment should occur with any significant change, annually or as deemed necessary..."</p> <p>On 2/10/15, R47 was admitted to the facility with diagnoses including Alzheimer's Disease/advanced dementia and anxiety.</p> <p>The admission "Data Collection Tool", dated 2/10/15, stated that R47's bladder function was both continent and incontinent. The form stated, "If incontinent is checked, complete required Bowel and Bladder forms". This tool also stated that R47 was dependent for transfers and toilet use.</p> <p>The "3-Day Bowel and Bladder Flow Sheet" was initiated for R47 at 4 PM on 2/10/15 when the resident was admitted. However, this 3 day voiding flow sheet was incomplete capturing only from 4 PM on 2/10/15 to 10 PM on 2/12/15 rather than 3 full days until 4 PM on 2/13/15. Additionally, from 11 PM on 2/11/15 through 6 AM on 2/12/15, the flow sheet was blank. The bladder flow sheet on 2/10/15 from 4 PM to 11 PM, stated that R47 was incontinent twice during that timeframe.</p> <p>The "Personal Care Record", completed by CNAs, for the evening shift on 2/10/15 from 4 PM to 11 PM, failed to agree with the bladder flow sheet for the same timeframe and stated that R47 was "I/C" (incontinent/continent) twice.</p> <p>Per the NN, dated 2/10/15 at 8 PM, R47 was admitted from the assisted living area, required assistance with all ADLs and transfers, and was</p> | F 315 | <p>care plan will be developed. The RNAC will inform the Director of Nursing/designee of all urinary changes with the residents' quarterly assessments. The Staff Development Coordinator, will in-service licensed nursing staff, annually and upon new hire orientation, on the three (3) day Bladder Flow Sheet and Bladder Incontinence Assessment. The Assistant Director of Nursing/designee will audit all three (3) day Bladder Flow Sheets for accuracy and completeness. This will identify the needs for incontinence assessment and care planning.</p> <p>4. The Director of Nursing/designee will audit the above stated process weekly times four (4) weeks until 100% compliant, then monthly times two (2) months until 100% compliant. The QAPI team will review all findings to identify trend and determine the need for continued audits.</p> | |

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| F 315 | <p>Continued From page 17</p> <p>both continent and incontinent of bladder.</p> <p>In the admission History and Physical, dated 2/10/15, R47's doctor noted that urinary was "-." indicating urinary was negative, indicating no issues. Additionally, there were no check marks noted for urgency or leakage of urine.</p> <p>The 3 day bladder flow sheet, dated 2/11/15 during nightshift, stated that R47 voided three times with no episodes of incontinence. However, the "Personal Care Record" failed to agree and stated that R47 was incontinent twice during nightshift on 2/11/15.</p> <p>R47's "Bladder Incontinence Assessment", dated 2/12/15, was incomplete and inaccurate. Bladder status was blank for onset and duration of incontinence. The "Bladder Continence" scale incorrectly stated that R47 had complete control of her bladder. The summary stated, "not recommended for Retraining Program; Reasons: Resident perception to void is absent. Resident unable to express her needs".</p> <p>The "Personal Care Record", completed by CNAs, stated that R47 was I/C twice during dayshift on 2/13/15 and once each on 2/14/15 and 2/15/15.</p> <p>The admission MDS assessment, dated 2/16/15, revealed that R47 was severely cognitively impaired, required extensive assistance of one person for transfers and toileting, was frequently incontinent of urine and bowel and had no trial toileting programs.</p> <p>R47's care plan entitled, "Resident experiences bladder incontinence r/t (related to) Dementia,</p> | F 315 | | |

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| F 315 | <p>Continued From page 18</p> <p>developed on 2/17/15 and last revised on 6/9/15, had goals to maintain current level of bladder continence with target dates of 5/17/15 and 8/18/15 and UTI will resolve in 7 days, dated 6/9/15. Approaches included: "Ensure adequate bowel elimination (inappropriate approach since this care plan is for urinary issues); Keep call light in reach; Obtain diagnostic tests as ordered; Obtain labs as ordered; Obtain OT consult prn; Provide assistance for toileting; Provide incontinence care after each incontinent episode; Report any signs of skin breakdown...; Report signs of UTI...; weekly skin checks...; 3/26/15 Cipro (antibiotic)... (for) 7 days for UTI; 6/9/15 Cipro... (for) 7 days...". However, there was no individualized approach based on R47's needs related to urinary continence.</p> <p>Review of "Personal Care Records", completed by CNAs, revealed the following urinary continence:</p> <ul style="list-style-type: none"> - From 2/17/15 to 2/28/15, R47 was incontinent of urine during all shifts; - During the month of March 2015, R47 was incontinent of urine during all shifts. <p>On 3/23/15, R47 was restless and her urine had a foul odor. R47's doctor ordered a UA with a C&S.</p> <p>On 3/26/15, R47's doctor ordered an antibiotic, Cipro, for 7 days based on the urine C&S which revealed the resident had an E. Coli UTI which was sensitive (responsive) to Cipro.</p> <p>Review of "Personal Care Records", completed by CNAs, revealed the following urinary continence:</p> <ul style="list-style-type: none"> - During the month of April 2015, R47 was incontinent of urine during all shifts; | F 315 | | |

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| F 315 | <p>Continued From page 19</p> <p>- During the month of May 2015, R47 was incontinent of urine during all shifts.</p> <p>The quarterly MDS assessment, dated 5/18/15, revealed that R47 was severely cognitively impaired, required extensive assistance of one person for transfers and toileting, was always incontinent of urine and frequently incontinent of bowel and had no trial toileting programs.</p> <p>On 6/8/15, per the NN at 7:30 AM, R47 was combative and agitated. A UA with C&S was done.</p> <p>On 6/9/15, R47's doctor ordered an antibiotic, Cipro, for 7 days and to call with the sensitivity when available.</p> <p>On 6/11/15, R47's urine culture and sensitivity which revealed that the resident had an E. Coli UTI which was sensitive to Cipro.</p> <p>Review of "Personal Care Records", completed by CNAs, revealed the following urinary continence: - During the month of June 2015, R47 was I/C twice for incontinence and twice for continence on June 1st during dayshift and she was incontinent of urine during all shifts until 6/19/15 when R47 was discharged to another long term care facility.</p> <p>During an interview on 8/4/15 at 1:22 PM, E4 (UM) stated when R47 was admitted on 2/10/15, she received information in report from the assisted living unit (ALU) that R47 was sometimes continent but at times she didn't know when she had to go and was incontinent. E4 further stated the admission data collection tool, dated 2/10/15, was based on report from the ALU</p> | F 315 | | |

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| F 315 | <p>Continued From page 20</p> <p>that R47 was both continent and incontinent. E4 reviewed the 3 day bladder flow sheet and stated since R47 was admitted on the 10th of February, then 3 days would be the 12th of February. However, since R47 did not arrive until 4 PM on 2/10/15, there was no opportunity to obtain voiding observations for night and day shifts on 2/10/15. E4 confirmed that the 3 day flow sheet was not complete and stated that she based her bladder incontinence assessment on the incomplete 3 day bladder flow sheet. E4 also reviewed the Personal Care Record for 2/11/15 and confirmed that it failed to match the bladder flow sheet confirming discrepancies. E4 reviewed the bladder incontinence assessment, dated 2/12/15, and stated she thought complete control meant emptying your bladder fully, rather than being in control of urine/continent. E4 confirmed the admission bladder incontinence assessment was not complete or accurate. E4 further stated, "I don't do the care plans, the MDS coordinator does". E4 agreed she could not tell what the individualized care plan for bladder incontinence was for R47 based on review of the care plan.</p> <p>During an interview, on 8/4/15 at 2:15 PM, E2 (DON) confirmed there was an incomplete 3 day bladder flow sheet and stated R47 should have had another 3 day bladder flow sheet done. E2 further confirmed the admission bladder incontinence assessment was inaccurate and incomplete, the personal care record for 2/11/15 failed to match what the 3 day bladder flow sheet stated for nightshift and there was no individualized care plan for bladder incontinence for R47.</p> <p>The facility failed to accurately assess R47's</p> | F 315 | | |

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| F 315 | Continued From page 21 urinary status upon admission, failed to complete a 3 day bladder flow sheet, failed to care plan accordingly based on the resident's individualized needs, failed to comprehensively reassess R47's urinary status and appropriately develop a care plan based on individualized needs. On 8/4/15, findings were confirmed by E2 and E4. | | 1. R14 remains stable in the facility. A rehab evaluation has been completed and the resident is on caseload to maximize transfer status. | 9/24/2015 |
| F 323 SS=G | 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 observations, record review, interviews and review of other documentation, it was determined that for two (R14 and R50) out of 24 Stage 2 sampled residents, the facility failed to ensure that the resident environment remained as free from accident hazards as was possible and that each resident received adequate supervision and assistance to prevent accidents. For R14, the facility failed to complete a transfer according to physician's orders by failing to utilize a transfer board and gait belt during the transfer or by utilizing a hooyer. On 7/27/15 at approximately 3:40 PM, the facility transferred R14 from her w/c to bed utilizing a gait belt and only one (1) staff. R14 sustained harm resulting in a skin tear and laceration during this transfer requiring an ER visit, three (3) sutures and | F 323 | 2. All residents who require assistance for transfers are at risk for this deficient practice. All residents will be evaluated by the Rehabilitation Department to identify transfer status. All residents with a noted decline in their transfer status will be actively treated by rehab. Once all residents' transfer status has been identified by rehab, clarifying orders will be obtained and the C.N.A.'s Resident Flow Sheet, C.N. A. Care Card and Care Plans, will reflect the resident's current transfer status. 3. The root cause analysis revealed that the transfer orders were not clear which lead to the staff member not transferring the resident appropriately. The Director of Nursing/designee will educate Rehab on how to write specific transfer orders | |

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| F 323 | <p>Continued From page 22</p> <p>administration of an antibiotic. For R50, the facility failed to remove aluminum bed rail holders when R50 no longer needed them, which posed a potential accident hazard. Findings include:</p> <p>1. R14 was originally admitted to the facility on 7/5/13 with diagnoses that included dementia and PVD.</p> <p>A physician's order, dated 7/14/14, stated, "Recommend use of transfer board and gait belt for transfers and use of hoyer lift as needed if resident is weak/unable."</p> <p>An OT Initial Evaluation and Treatment, dated 2/9/15, stated "...referred to Occupational Therapy secondary to:...Functional decline -affecting independence, adequacy, and safety in ADLS including bed mobility, transfers, wheelchair mobility...Previous Level of Function: Transfer Ability - minimal...Transfers: Patient performed stand pivot transfer from a bed and wheelchair to a bed and wheelchair, requiring total physical assistance...verbal instruction and visual demonstration. With guard belt...Goals:...Transfer: Patient will perform stand pivot transfer from a bed and wheelchair to a bed and wheelchair, requiring minimal tactile facilitation and verbal instruction in 90 days. This goal was established on 02-09-15..."</p> <p>An OT Discharge Report, for the service dates of 2/9/15 through 3/20/15, stated, "...Transfers: Most Recent Treatment Patient performed stand pivot transfer from a bed and wheelchair to a bed and wheelchair, requiring total physical assistance, tactile facilitation, verbal instruction and visual demonstration. Increased time was required secondary to poor technique, strength, balance,</p> | F 323 | <p>that leave no ambiguity. All new/updated transfer orders will be brought to Clinical Morning Meeting, along with the care plan, C.N.A. Care Cards and the ADL Flow Sheet, to ensure consistency with the new order. The Staff Development Coordinator will educate all licensed staff and C.N.A.'s on residents' current and new transfer status, as needed.</p> <p>4. The Director of Nursing/designee will audit all new transfer orders against the C.N.A Care Cards, care plans and ADL Flow Sheets weekly, times four (4) weeks until 100% compliant and monthly, times two (2) months, until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits.</p> <p>1. R 50 remains in the facility with no adverse effect and side rail holder was removed.</p> | |

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| F 323 | <p>Continued From page 23</p> <p>coordination, motivation, and cognition...Clinical Impression: Pt discharged from skilled occupational therapy services secondary to maximizing independence, adequacy, and safety in daily routines including...transfers...Limited progress made throughout therapy services secondary to low motivation and musculoskeletal deficits..."</p> <p>A PT Initial Evaluation and Treatment, dated 2/10/15, stated, "...Clinical Impression:...Patient has been non-ambulatory for at least two years and patient's non-compliance with transfers has resulted in weakness and an increase in dependence...Goals Transfer: Patient will perform sit to and from stand transfer from a wheelchair, requiring maximum physical assistance and verbal instruction in order to demonstrate increase in BLEs in 90 days. This goal was established on 02-10-15..."</p> <p>A PT Discharge Report, for the service dates of 2/10/15 through 3/12/15, stated, "...Most Recent Treatment - Patient unable to perform sit to and from stand transfer from a wheelchair using an armrest/grab bar, using both upper extremities secondary to compromised balance, cognition, coordination, safety, strength/ROM and technique. Goals: Patient will perform sit to and from stand transfer from a wheelchair...This goal was established on 02-10-15. It is discontinued secondary to Patient refused attempts to stand, on 3-12-15..."</p> <p>An OT Treatment Encounter, dated 3/3/15, stated "Pt very upset today. Complaining of shoulder pain secondary to transfers...staff education, requiring moderate verbal instruction and visual demonstration. Staff educated on use of guard</p> | F 323 | <ol style="list-style-type: none"> 2. All residents are at risk for this practice. The Director of Facilities inspected all beds for side rail holders not in use. It was noted that no other used side rail holders were identified. 3. Root cause analysis revealed that when the bed mobility equipment was removed the holder was inadvertently left on the bed. The Director of Facilities will add the inspection of side rail holders to the monthly environmental rounds. The Environmental Director will in-service the maintenance staff on the inclusion of bed rail holders to the environmental rounds. 4. The Director of Facilities will randomly inspect 10% of all beds, weekly, times four (4) weeks, until 100% compliant, every two (2) weeks, times four (4) weeks, until 100% compliant and then quarterly. The results will be reviewed by QAPI to identify trends and findings to | |

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| F 323 | <p>Continued From page 24 belt to improve safety during transfers and decrease pt fear and discomfort. Education for body mechanics and technique..."</p> <p>A "Note To Rehabilitation," completed by nursing when requesting a therapy evaluation, dated 3/26/15, had checked off "Resident is having difficulty with transfers." This same note, completed at the bottom by OT on 3/31/15, stated "Pt recently discharged from OT/PPT services and is at baseline."</p> <p>A care plan was initiated on 4/3/15 for the problem of being at risk for falling related to impaired balance during transition. Approaches included "hoyer lift for transfers as needed; transfer board or gait belt as needed". This approach was contrary to a 7/14/14 physician's order which stated "Recommend use of transfer board and gait belt for transfers and use of hoyer lift as needed if resident is weak/unable."</p> <p>A care plan, dated 4/3/15, for the problem of being at risk for skin breakdown and skin tears had a notation dated 7/27/15 that R14 had a skin tear/open area on the L lower extremity. A second notation, dated 7/22/15, stated, "2 person for all transfer." It is unclear whether the date of this second notation was entered correctly.</p> <p>R14's annual MDS assessment, dated 7/27/15, stated the following (during the seven [7] day review period):</p> <ul style="list-style-type: none"> - daily decision making skills were severely impaired; - did not ambulate in room or corridor; - required extensive assistance of one staff for moving about the unit in a wheelchair; - total dependence on two (2) staff for transfer; | F 323 | determine the need for continued audits. | |

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| F 323 | <p>Continued From page 25</p> <p>- ROM: impairment of both upper and lower extremities (limitations that interfere with daily functions or place resident at risk of injury);</p> <p>- during surface-to-surface transfer (transfer between bed and chair or wheelchair) the resident was not steady, only able to stabilize with staff assistance.</p> <p>Review of nurse's notes from 4/27/15 through 7/24/15 revealed the following: 4/27/15 11:05 AM - "...assist of 2 c gait belt and sliding board..." 4/27/15 9:35 PM - "...assist of 2 c transfer c gait belt and sliding board..." 4/30/15 (untimed) - "...unable to do full range of motion on both upper extremities...transfer is usually c hooyer lift, patient unable to fully stand, needs 2 person assist c gait belt use." 7/3/15 3:10 PM - "...Resident scare (sic) c hooyer lift transfer this afternoon when 2 CNA assisting her..." 7/21/15 4:00 AM - "...is an extensive with assistance and transfer..." 7/22/15 (untimed) - "...is an extensive assist with ADLs and transfer..." 7/24/15 6:00 AM - "...is a total care with ADLs and transfer..."</p> <p>A Staff In-Service Summary & Attendance Record, dated 5/28/15, was provided to the surveyor during the survey. This document stated, "Content: (name of therapy provider) Rehab to in-service on transfers. They will demonstrate and observe return demonstrations." A separate document included with the in-service, titled "Transfers & Mobility Assistance Techniques" stated, "...One Person Stand-Pivot Transfer - ...With small steps, turn your feet with resident in the direction you wish to move..."</p> | F 323 | | |

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| F 323 | <p>Continued From page 26</p> <p>Review of the attendance record for the 5/28/15 in-service revealed that E13 (CNA) attended.</p> <p>Review of the July 2015 monthly POS revealed the order, originally dated 7/14/14, that stated, "Recommend use of transfer board and gait belt for transfers and use of hooyer lift as needed if resident is weak/unable." The July 2015 monthly POS was signed off by the physician after review on 7/2/15.</p> <p>The July 2015 TAR stated, "07/14/14 (date of original order) Recommend use of transfer board and gait belt for transfers and use of hooyer lift as needed if resident is weak/unable FYI."</p> <p>Review of R14's July 2015 CNAADL documentation revealed that a separate binder was utilized for each of the three (3) shifts. Nurse Aide's Information Sheets (identified specific care CNAs were to provide including how to complete transfers) were found in each of the three (3) binders. The following was written on the sheets: - Day Shift - checked off or listed: with 1 assist, with 2 assist, other hooyer PRN, gait belt and sliding board; - Evening Shift - checked off for assist transfers with 1 assist; - Night Shift - checked off for assist transfers with 1 assist.</p> <p>The facility failed to correctly and consistently identify R14's transfer status on all three of the Information Sheets as per the 7/15 POS, which stated, "Recommend use of transfer board and gait belt for transfers and use of hooyer lift as needed if resident is weak/unable."</p> <p>Review of the Resident Monthly Personal Care Record, completed by day shift CNAs, revealed</p> | F 323 | | | |

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| F 323 | <p>Continued From page 27</p> <p>that from 7/1/15 through 7/15/15, R14 was totally dependent on staff for transfers. On six (6) of the 15 days, R14 required the assist of two (2) staff for transfers. From 7/16/15 through 7/30/15, it was documented that R14 was totally dependent on 2 staff for transfers. There was no evidence that a sliding board and gait belt were used during these transfers.</p> <p>Review of the Resident Monthly Personal Care Record, completed by evening shift CNAs, revealed that from 7/1/15 through 7/15/15, R14 was totally dependent on staff for transfers. On seven (7) of the 15 days it was documented that R14 required the assist of two (2) staff for transfers. From 7/16/15 through 7/30/15, it was documented that R14 was totally dependent on 2 staff for transfers, except for 7/27/15 when it was documented that R14 was totally dependent on one (1) staff for transfer. There was no evidence that a sliding board and gait belt were used during these transfers.</p> <p>Review of the Resident Monthly Personal Care Record, completed by night shift CNAs, revealed that from 7/1/15 through 7/30/15, R14 was not transferred.</p> <p>The Monthly Nursing Summary, dated 7/9/15, stated R14 was alert, but had short and long term memory problems, was severely impaired for decision making, and was totally dependent for transfers.</p> <p>The facility's incident report and investigation revealed the following: - 7/27/15 3:45 PM - written statement completed by E13 - "I had transfer (sic) her into bed when I pulled down her stockings blood started to drip..."</p> | F 323 | | |

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| F 323 | <p>Continued From page 28</p> <p>- 7/27/15 5:00 PM written statement signed by E2 (DON), E3 (ADON) and E13 (CNA) stated, "At approx..1700 (5:00 PM) we (DON and ADON) asked CNA (E13) if it was possible if this injury could have occurred while she was transferring the resident from w/c to bed. And that this was a new, refresh (sic) injury. CNA (E13) agreed and said, "I could have done it when I transferred her to the bed...If resident is difficult to transfer then you should ask for assistance and notify the charge nurse."</p> <p>Review of nurse's notes revealed the following:</p> <p>- 7/27/15 5:00 PM - "At 1540 (3:40 PM) I was called in to the resident's room and found resident sitting on her bed with a skin tear on left lower extremity...measuring 8 cm x 10 cm. Resident does not recall how she got the skin tear...Called Dr. (name) and she ordered to cleanse wound...also ordered PT/OT eval and 2 person assist for all transfers...she (R14) complained of moderate pain...offered medication..."</p> <p>- 7/28/15 6:00 AM - "...being monitored for a big skin tear on the left leg, bleeding stop (sic)..."</p> <p>- 7/28/15 10:00 AM - "Scant amt bleeding noted this am...Awaiting for Nurse Practitioner to assess resident..."</p> <p>- 7/28/15 11:05 AM - "Ultram (pain medication)...given...pain L lower leg/skin tear/laceration...dressing clean & dry..."</p> <p>7/28/15 12:25 PM - "...seen & examined by (name) NP. Obtained order to sent (sic) to (name) ER for Lt shin laceration..."</p> <p>- 7/28/15 1:02 PM - "Resident pick-up by ambulance at 12:58 PM."</p> <p>A progress note completed by the NP, dated 7/28/15, stated "L leg laceration asked to see pt 2</p> | F 323 | | |

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| F 323 | <p>Continued From page 29</p> <p>(secondary to) eval L leg laceration sustained yesterday. Unclear how she sustained it...L lateral aspect of leg c large deep skin laceration c bloody discharge...Plan: L leg laceration...pt requires ER eval for sutures - will require oral abx..."</p> <p>Review of the ER discharge instructions, dated 7/28/15, revealed that R14 required placement of three (3) sutures to the LLE.</p> <p>Review of physician's orders, dated 7/28/15, revealed R14 required daily dressing changes to the LLE wound and required administration of an antibiotic three (3) times a day for seven (7) days for wound prophylaxis (prevention of infection).</p> <p>A Staff In-Service Summary & Attendance Record, dated 7/29/15, was provided to the surveyor during the survey. The document stated, "Subject:...Resident Safety-Transfer, ADLs Documentation...If patient is a total assist with self performance, there should be 2 person (sic) helping her...Pt should always be 2 person if patient is total dependent."</p> <p>A typed letter, dated 7/30/15, submitted to the State Agency by E1 (NHA) stated, "...On Monday, July 27, 2015, at approximately 3:45 pm, (R14) sustained a skin tear to her left, lateral shin, while being transferred by her assigned caregiver...On Tuesday, July 28, 2015, the nurse practitioner evaluated (R14) and ordered to send her to the emergency room for an evaluation and treatment. (R14) received three (3) sutures to her left, lateral shin. When the Social Services Director interviewed (R14) and asked her what happened, (R14) stated that she didn't know, but while sitting (sic) her chair, it felt like a scissor-like object.</p> | F 323 | | |

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| F 323 | <p>Continued From page 30</p> <p>Assessment of her wheelchair by the Director of Nursing did not reveal any sharp edges throughout (R14's) chair and the Director of Nursing and Executive Director's interview with the CNA involved, along with further investigation, revealed that the incident occurred at the time the CNA reported it to her supervisor. Although it has been determined that the CNA assigned to (R14), had followed the appropriate steps during her transfer, the CNA also acknowledged that she may have been responsible for the sustained skin tear...although she doesn't know how it occurred. One-on-one teaching and re-education has been provided with the CNA involved. In addition, the CNA has also been instructed to call for assistance if the transfer becomes difficult. A physical therapy and occupational therapy consultation has been ordered to re-evaluate (R14's) transfer method - the evaluation is currently pending. The Director of Nursing has also recommended that we utilize our current transfer method with an additional stand-by assist."</p> <p>On 7/30/15 at 10:58 AM, an OT recommendation order was written that stated, "Recommendation for 2 person assist SPT with use of gait belt."</p> <p>On 8/3/15 at 10:30 AM, E11 (CNA) was interviewed. E11 stated that she has worked with R14 since her transfer to the unit, that she (E11) has to complete all of R14's ADLs, the resident does not ambulate, cannot stand and requires a two (2) person assist with transfers using a gait belt. E11 stated R14 has been a 2 person transfer since coming to their unit and sometimes a Hoyer lift is used, but the resident doesn't like the Hoyer. E11 stated this morning she transferred R14 using a gait belt with the assist of a second</p> | F 323 | | | |

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| F 323 | <p>Continued From page 31 person.</p> <p>On 8/3/15 at approximately 11:05 AM, E2 stated after the incident, E13 (CNA) was educated about proper transfer of the resident and that the facility has been doing ongoing education for all staff in proper transfers.</p> <p>On 8/3/15 at 11:28 AM, E11 and E12 (CNA) were observed transferring R14 from a recliner to her w/c in the lounge area. Upon waking R14, E11 explained to the resident what they were going to do and she appeared to understand. After placing a gait belt on the resident they positioned and locked the w/c. Then, with one CNA on each side of R14, they grabbed hold of the gait belt and placed their other arm under the residents' and told her on the count of three (3), they would transfer her to the w/c. On the count of three (3), E11 and E12 lifted the resident from the recliner. R14 was observed not standing or bearing any weight on her legs during the transfer.</p> <p>On 8/3/15 at approximately 12:30 PM, C1 (PT) was interviewed and stated that R14 should have been transferred according to the last order written on 7/14/14, "Recommend use of transfer board and gait belt for transfers and use of hooyer lift as needed if resident is weak/unable."</p> <p>On 8/3/15 at approximately 12:40 PM, C2 (OT) was interviewed and stated that she did not have a valid order to evaluate and treat R14 last week after the incident, so she was only able to observe while two (2) staff transferred R14 using a gait belt and SPT. C2 stated they transferred R14 from bed to w/c and did not appear to use their full strength or be exerted. C2 stated today she got a valid order to evaluate and treat R14</p> | F 323 | | |

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| F 323 | <p>Continued From page 32</p> <p>and confirmed that when she attempted to transfer R14, the resident was not able to stand. Additionally, C2 stated she was not able to locate the transfer board, thus she was recommending use of a Hoyer with 2 staff, as the facility had a "no lift" policy and that anyone who is totally dependent is a lift transfer.</p> <p>On 8/3/15 at approximately 2:45 PM, E8 (RN/evening supervisor) was interviewed. E8 stated while seated at the nurse's station on 7/27/15, he observed R14's call light on and went to the room. E8 stated he observed E13 (CNA) in the room with R14, who was seated at the edge of the her bed, wearing TED stockings on both legs with the left one pulled down to the ankle. "I saw this big skin tear/laceration." E8 stated the area was bleeding and he asked E13 what happened? E13 responded that she didn't know, she just saw it. E8 stated he asked the resident what happened, as she had an injury, and she stated she didn't know. E8 stated at that point he notified E3, who then notified E2. E8 stated both E2 and E3 came and looked at R14's leg and then called E9 (SW) to interview the resident. E8 stated it was an "8 x 10 cm skin tear, flap opened on LLE." E8 said he then called the NP, told her about the injury and said "We will probably be sending her out." E8 stated he was informed by E2 that R14's daughter was spoken to and it was agreed that R14's wound would be monitored in house and she would be seen by the MD or NP the next day. E8 stated he then called the physician's service and obtained treatment orders. E8 stated he could tell R14 had just been transferred from the w/c to her bed because the w/c was next to the bed and the resident was at the edge of the bed. Additionally, E8 stated it was a "fresh" wound. E8 confirmed there was no</p> | F 323 | | | |

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| F 323 | <p>Continued From page 33</p> <p>Hoyer lift in the room and stated he did not recall any other equipment, such as a transfer board.</p> <p>On 8/3/15 at 3:10 PM, E13 was interviewed. E13 stated she has worked with R14 regularly since R14 came to their unit. E13 stated the resident was tired that evening and asked to be put to bed. E13 stated she asked the supervisor if she could lay R14 down, as it was too early for bed, and he stated yes. E13 demonstrated the transfer in R14's room. E13 stated she wheeled the resident into her room, positioned the w/c near the foot of the bed, applied the gait belt and pivoted her over to the bed. When asked if R14 was able to stand, E13 stated the resident was able to hold on to you with her arms around you. E13 stated while R14 was seated at the edge of the bed, she pulled down her left TED hose and noticed blood and she immediately rang the call bell for help. Observation of the w/c revealed no sharp edges, however the legs of the w/c above the wheels were wrapped with black electrical tape creating a bulge, and when in the locked position, the w/c brake latch protruded slightly. The facility failed to ensure that a totally dependent resident was transferred according to physician's orders. The facility failed to utilize both a transfer board and gait belt or a Hoyer lift according to physician's orders.</p> <p>On 8/4/15 at approximately 10:15 AM, C2 was interviewed. C2 stated she had not completed documenting her evaluation of R14, but has placed a recommendation regarding transfers in the physician's book to be signed. C2 stated she recommended transfers SPT with 2 assist and gait belt or hoyer lift when needed, with the "S" being more sit than stand during the transfer. She stated that if staff are utilizing proper body</p> | F 323 | | |
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| F 323 | <p>Continued From page 34</p> <p>mechanics during the transfer they can continue with the SPT with 2 staff or utilize a hoyer when needed.</p> <p>On 8/4/15 at 11:40 AM, findings were reviewed with E2 and E14 (RDH) regarding R14 being transferred inappropriately and unsafely when staff failed to utilize both a transfer board and gait belt or Hoyer lift with two (2) staff present. The facility instead transferred R14, a totally dependent resident, utilizing only a gait belt and one (1) staff resulting in a significant injury and harm to R14. E2 stated she disagreed and interpreted the 7/14/14 order as "use a transfer board OR gait belt OR Hoyer lift."</p> <p>On 8/4/15 at 12:10 PM during an interview with C1, she was asked as a therapist, what her interpretation of the 7/14/14 order meant? C1 stated that to her it means a transfer board AND gait belt OR hoyer. C1 also agreed that since the order was recently changed to a two (2) person assist with gait belt SPT by C2, it would signify that it was unsafe for R14 to be transferred by one staff person.</p> <p>On 8/4/15 at 12:20 PM, E1 and E2 were again interviewed. E2 stated she agreed that the CNA care cards for the three (3) shifts were inconsistent regarding R14's transfers. E1 stated that the CNA transferred R14 properly on 7/27/15 based on their interpretation of the 7/14/14 order, and if they felt it was an incorrect transfer, she (CNA) would have been disciplined. E2 further stated that although R14 had a laceration, she didn't have a tear in the TED stocking and it was inconclusive as to how R14 got the injury.</p> <p>On 8/6/15 at 4:12 PM, the OT Initial Evaluation</p> | F 323 | | |

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| F 323 | <p>Continued From page 35</p> <p>and Treatment, dated 8/3/15, was received via email from the facility. It stated, "...referred to Occupational Therapy secondary to: Injury - skin tear to L posterior calf requiring stitches during transfer...Functional decline - affecting independence...and safety in ADLS including...transfers...Patient/caregiver Comments: She has been getting much harder to transfer...Activities:...Transfers Patient performed sit to and from stand transfer from a wheelchair, requiring total physical assistance...secondary to compromised...balance, cognition, coordination, safety, strength/ROM and technique...Treatment Encounter...Transfers:...requiring total physical assistance...Pt able to maintain stand for approximately 5 (five) seconds before needing to sit. Recommendation for staff to complete 2 person assist for SPT when appropriate and hoyer lift PRN to increase safety and adequacy of transfers..."</p> <p>The facility failed to transfer R14 according to physician's orders by failing to utilize both a transfer board and gait belt or a hoyer lift. On 7/27/15 at approximately 3:40 PM, the facility transferred R14 from her w/c utilizing only one (1) staff and a gait belt. R14 subsequently sustained a skin tear and laceration requiring an ER visit, three (3) sutures and administration of an antibiotic.</p> <p>2. An observation on 7/31/15 at 8:55 AM revealed R50's aluminum bed rail holders were attached near the head of the bed; they extended beyond the height of the mattress and posed a potential accident hazard.</p> <p>In a follow-up observation and combined interview on 8/3/15 at 2:04 PM, E4 (UM) stated</p> | F 323 | | |

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| F 323 | Continued From page 36 that R50 does not need bed rails. E7 (MD) stated he would remove the bed rail holders immediately. E4 and E7 confirmed the finding and agreed that the bed rail holders posed a potential accident hazard. | | | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | <ol style="list-style-type: none"> Chart of R6 was reviewed and baseline AIMS have been completed. Quarterly AIMS tests have been scheduled to meet the standard practice of completing AIMS testing. AIMS testing will be conducted quarterly. All residents who are receiving Antipsychotic medications have the potential to be affected by this deficient practice. An audit of all residents receiving antipsychotic medications will be completed to identify AIMS completion /baseline. Any missing AIMS tests will be completed to identify baseline. The root cause analysis revealed that the unit managers were unaware of the AIM testing protocol and the RNAC did not list the AIMS testing in the interventions of the care plan. All current residents who are newly prescribed antipsychotic or new admissions, with antipsychotic medication prescriptions, will have a baseline AIMS test completed. | 10/2/2015 |

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| F 329 | Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs related to monitoring for 2 (R6 and R30) out of 24 stage 2 sampled residents. The facility failed to obtain a baseline AIMS test for R6 and AIMS tests every 6 months for R30 as recommended by the consultant pharmacist, to monitor for abnormal movements as side effects with usage of antipsychotic medication. Findings include: Cross refer F280, example #1 1. R30 was admitted to the facility on 3/4/14. R30's admission MDS, dated 3/5/15, indicated he was receiving antipsychotic medication. A baseline AIMS assessment was completed on 3/4/14. Review of R30's care plan for being at risk for adverse effects related to receiving antipsychotic medication, dated 3/5/15 lacked an intervention to do an AIMS assessment every 6 months. A consultation report by the consultant pharmacist, dated 10/9/14, stated, "... an AIMS... assessment is not documented in the resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... at least every six months thereafter (or per facility protocol)...". Although the facility did a baseline AIMS for R30, they failed to perform another AIMS until 10/13/14; 39 days | F 329 | The subsequent AIMS test will be scheduled every six (6) months. All licensed nursing staff will be in-serviced annually and upon new orientation, by the Staff Development Coordinator, on timeframes required for AIMS testing by licensed nursing staff. 4. The Director of Nursing will audit 10% of scheduled AIMS test weekly, times four (4) weeks until 100% compliant, every two (2) weeks for two (2) months until 100% compliant, then quarterly until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits. | | |

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| F 329 | <p>Continued From page 38 after it was due (due 9/4/14).</p> <p>A consultation report by the consultant pharmacist, dated 5/5/15, stated, an AIMS... assessment is not documented in the resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... at least every six months thereafter (or per facility protocol)...". The facility performed an AIMS assessment on 5/5/15; 22 days after it was due (due 4/13/15).</p> <p>Despite pharmacy recommendations on 10/9/14 and 5/5/15, the facility failed to perform AIMS assessments for R30 at least every 6 months.</p> <p>2. R6 was admitted to the facility on 4/10/15. The admission nursing assessment, dated 4/10/15, identified that R6 was taking an antipsychotic.</p> <p>The facility initiated an undated admission care plan for use of psychotropic medications (includes antipsychotics). The rest of the admission care plan was dated 4/10/15. The psychotropic medication care plan was preprinted and listed an intervention for "... Complete a baseline AIMS test if I'm on antipsychotic medication and per policy thereafter...", however, this was not checked to be done for R6.</p> <p>On R6's admission MDS assessment, dated 4/16/15, he was identified as being on an antipsychotic.</p> <p>During the MRR on 5/6/15 the consultant pharmacist identified the lack of a baseline AIMS for R6 and notified the facility. The consultation report by the pharmacist, dated 5/6/15, stated, "... an AIMS... assessment is not documented in the</p> | F 329 | <ol style="list-style-type: none"> 1. Chart of R30 was reviewed and the AIMS test was not completed every six (6) months. 2. All residents who are receiving Antipsychotic medications have the potential to be affected by this deficient practice. An audit of all residents receiving antipsychotic medications will be completed to identify AIMS completion /baseline. Any missing AIMS tests will be completed to identify baseline. 3. The root cause analysis revealed that the unit managers were unaware of the AIM testing protocol and the RNAC did not list the AIMS testing in the interventions of the care plan. All current residents who are newly prescribed antipsychotic or new admissions, with antipsychotic medication prescriptions, will have a baseline AIMS test completed. The subsequent AIMS test will be scheduled every six (6) months. All licensed nursing staff will be in-serviced | |

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| F 329 | Continued From page 39 resident record within the previous 6 months... Please consider monitoring for involuntary movements by using... AIMS... now and then at least every six months thereafter (or per facility protocol)...". Record review revealed that an AIMS was completed for R6 by the facility on 5/6/15 (26 days after admission). The 5/6/15 AIMS test revealed a "1" minimal/normal (as compared to "0" none) movements of the lips/area surrounding mouth (for example, puckering, pouting smacking). Review of R6's permanent care plan for psychotropic drug use, dated 4/16/15, continued to lack an intervention for AIMS testing despite the pharmacist's recommendations on 5/6/15. During an interview with E6 (UM) on 8/3/15 at 10:17 AM, E6 stated the facility does not have a policy for AIMS assessments (in contrast to the above mentioned intervention on the admission care plan), they are done based on pharmacy recommendations. When asked if the pharmacy had a policy for AIMS testing, E6 stated there was not. E6 confirmed she knew R6 was on an antipsychotic on admission, but she did the AIMS the same day the pharmacy recommended it on 5/6/15. | F 329 | annually and upon new orientation, by the Staff Development Coordinator, on timeframes required for AIMS testing by licensed nursing staff. 4. The Director of Nursing /designee will audit all new admissions with prescribed antipsychotic medications and residents with newly prescribed antipsychotic medications for baseline AIMS times four (4) weeks until 100% compliant, every two (2) weeks for two (2) months until 100% compliant, then quarterly. The Director of Nursing will audit 10% of scheduled AIMS test weekly, times four (4) weeks until 100% compliant, every two (2) weeks for two (2) months until 100% compliant, then quarterly until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits. | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or | | | |

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| F 371 | <p>Continued From page 40 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to distribute and serve food under sanitary conditions in one out of three dining areas. Also, the facility failed to have a handwashing sink that was convenient and accessible to the ware washing area. Findings include:</p> <p>1. A dining observation was made on 7/29/15 at 12 PM in the independent dining room on the second floor. At 12:00 PM and again at 12:03 PM, E19 (Dietary Services) was observed washing her hands and shutting off the faucet with her bare hands twice, potentially recontaminating them. Then, she dried her hands with paper towels. At 12:05 PM, a third observation was made of E19 in which she washed her hands, turned the faucet off with a paper towel and then dried her hands further with the same paper towel, again potentially recontaminating them. E19 confirmed the findings and stated that she was nervous.</p> <p>2. The handwashing sink in the dishwashing area was blocked by a cart on two observations. The blocked handwashing sink was observed on 7/29/15 during a kitchen tour from 12:47 PM to</p> | F 371 | <ol style="list-style-type: none"> No residents were affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The Staff Development Coordinator will in-service all dietary staff on proper hand washing techniques both annually and during new hire orientation. The Food & Beverage Director/designee will conduct random audits weekly, times four (4), until 100%, then monthly, times two (2), until 100%, to ensure team members are using proper hand washing techniques during meal service. The Food & Beverage Director/designee will review audit findings during the QAPI team meetings. <ol style="list-style-type: none"> No residents were affected by this deficient practice. All residents have the potential to be affected by this deficient practice. | 10/2/2015 |

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| F 371 | <p>Continued From page 41</p> <p>1:02 PM and on a tour with E5 (FSD) on 7/30/15 from 9:40 AM to 10:00 AM. E5 confirmed the finding and stated that staff use the other handwashing sink (in the food preparation area). The practice of walking across the kitchen to use the second handwashing sink was observed on both tours of the kitchen.</p> <p>The facility failed to have a handwashing sink that was not blocked and convenient and accessible to the ware washing area.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 8/4/15 at approximately 4:45 PM.</p> <p>F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature</p> | F 371 | <p>3. The Staff Development Coordinator will in-service all dietary staff on proper hand washing techniques both annually and during new hire orientation.</p> <p>There are two (2) hand washing sinks in the kitchen with the most commonly used sink being located in the center of the kitchen.</p> <p>4. The Food & Beverage Director/designee will conduct random audits weekly, times four (4), until 100%, then monthly, times two (2), until 100%, to ensure team members are using proper hand washing techniques during meal service.</p> <p>The Food & Beverage Director/designee will review audit findings during the QAPI team meetings.</p> | |

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| F 431 | <p>Continued From page 42</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to remove expired medications to facilitate the safe administration of medications in one out of two medication storage rooms. The facility failed to remove an expired box containing (8) eight medications used for nebulizer treatments for R9 from the locked cabinet in the medication storage room on the third floor. Findings include:</p> <p>R9's physician orders, dated 7/2/15, included an order for an inhalation medication, Ipratropium Bromide and Albuterol Sulfate Inhalation Solution, used in nebulizers four times a day as needed for wheezing/shortness of breath.</p> <p>On 7/29/15 at 11:15 AM, an observation was made of the 3rd floor medication storage room. There was a box of eight inhalation medications, Ipratropium Bromide and Albuterol Sulfate Inhalation Solution, used in nebulizer treatments, as needed for R9 which expired June 2015.</p> | F 431 | <ol style="list-style-type: none"> R9 no longer resides in the facility. All residents have the potential to be affected by this deficient practice. An audit of all medication rooms and medication carts has been conducted and all expired medications have been removed and/or destroyed. Root cause analysis revealed that the nursing staff failed to inspect the medication room and medication cart for expired medications. The 11-7 shift nursing supervisors will be required to inspect all medication carts, daily, for expired medications. the Staff Development Coordinator will in-service all nursing staff on the Expired Medications policy. The Director of Nursing/designee will review the audits daily. The Director of Nursing/designee will randomly inspect the medication rooms and medication carts, weekly times four (4) weeks until 100% compliant, then monthly until 100% compliant. The QAPI team will review all findings to identify trends and determine the need for continued audits. | 10/2/2015 |

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| F 431 | Continued From page 43 In an interview, on 7/29/15 at 11:30 AM, E4 (RN UM) confirmed that R9 still had an as needed order for the medication and stated that the 8 expired inhalation medications should have been wasted/ disposed of at the end of June. E4 further stated that she concentrated on the refrigerator more that the cabinet with medications in the medication storage room, "I can't lie to you, I haven't done the cabinet recently". The facility failed to remove expired medications from the third floor medication storage room. On 7/29/15, findings were confirmed by E4 as noted above. | | 1. R50 remains in the facility with no adverse effect related to this deficient practice. HgB A1C was drawn on 8/4/2015. 2. Any resident with an order to obtain HgB A1C, is at risk for this deficient practice. All residents who have a HgB A1C order, will be audited to ensure their labs have been drawn. 3. Root cause analysis revealed that there was a breakdown in the lab company's system and that the nurse inadvertently documented that the lab had been drawn. All residents who are receiving a HgB A1C every three (3) months will be placed on a Lab Tracking Form to ensure labs are timely drawn. The Regional Director of Health and Wellness will in-service the Director of Nursing/designee, times one (1) and as needed, regarding the Lab Tracking Form. | 10/2/2015 |
| F 502 SS=D | 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Cross refer F309, example #2 Based on record review and interview, it was determined that for one (R50) out of 24 Stage 2 sampled residents, the facility failed to obtain laboratory services for a Hgb A1C blood test on 7/16/15 for R50. Findings include: A physician's order, dated 4/17/15, stated to obtain a Hgb A1C in 3 months for a diagnosis of diabetes. Review of R50's July 2015 TAR revealed that Hgb A1C was signed off as "done" on 7/16/15. | F 502 | | |

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| F 502 | Continued From page 44 | F 502 | 4. The Director of Nursing will reconcile the Lab tracking Form versus the actual lab obtained, to ensure compliance with the physician's orders, q week times four (4). The QAPI team will review all findings to identify trends and determine the need for continued of audits. | |
| F 514 SS=D | <p>During an interview on 8/3/15 at 9:21 AM, E4 (UM) called the laboratory and confirmed that R50's blood test was not done. The facility failed to obtain laboratory services as per the 4/17/15 physician's order.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 8/4/15 at approximately 4:45 PM.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to have clinical records for 2 (R6 and R37) out of 24 stage 2 sampled residents in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Findings include:</p> | F 514 | <p>1. R6 remains in the facility with no adverse effect.</p> <p>2. All residents have the potential to be affected by this deficient practice. The facility reviewed and consolidated BM records, to be located in one place on each floor. This will decrease the likelihood of missed documentation and give easier access for review.</p> <p>3. A new BM Log Form has been developed to consolidate documentation for easier access and review. This form will be in a binder, located at the nurses' station on each floor. The Staff Development Coordinator will</p> | 10/2/2015 |

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| F 514 | <p>Continued From page 45</p> <p>1. During a medication review for R6, nurse's notes revealed that the resident received two medications for constipation namely Ducalox suppository on 5/3/15 (evening shift) and Milk of Magnesia (MOM) on 6/12/15 (day shift).</p> <p>Review of the May and June 2015 MARs revealed lack of documentation by nurses that a Ducalox suppository was administered on 5/3/15 and MOM on 6/12/15.</p> <p>Concerns were discussed with E6 (UM) during an interview on 8/4/15 at 8:50 AM. When asked about a time frame that records indicated R6 had had no BM, E6 showed the surveyor that R6 had MOM on 6/28/15 (day shift) with no results followed by a Ducalox suppository on 6/28/15 (evening shift) with results. The information was found on a BM audit tool used by E6. E6 additionally used 24 hour shift reports to find information. The BM audit tool and 24 hour shift reports were locked in the medication room behind the desk on the 2nd floor.</p> <p>The BM log and ADL sheets for R6, used to record BM's, lacked documentation that R6 had a BM on 6/28/15 and the June 2015 MAR lacked documentation that MOM and a Ducalox suppository were administered on 6/28/15.</p> <p>The facility failed to have complete and accurate BM and medication documentation for R6 that was readily accessible.</p> <p>2. R37 was admitted to the facility on 8/22/14.</p> <p>The admission MDS assessment, dated 8/25/14,</p> | F 514 | <p>in-service all licensed staff, annually and during new hire orientation.</p> <p>4. The Director of Nursing or designee will audit 10% of the new forms for accessibility and completeness, weekly, times four (4), until 100%, then monthly, times two (2), until 100%. The QAPI team will review all findings to identify trends and determine a need for continued audits.</p> <p>1. R37 remains in the facility with no adverse effect. Documentation of R37's refusal of the pneumococcal vaccination was documented on the consent form. The pneumococcal vaccine consent form was also signed by R37.</p> <p>2. Those residents found not to have a signed consent, was provided a new consent form, giving them an opportunity to consent or decline and give reason for refusal.</p> | |
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| F 514 | <p>Continued From page 46</p> <p>stated R37 was independent for daily decision making skills.</p> <p>Review of R37's Resident Immunization Consent Form revealed that the portion for pneumococcal vaccine administration was blank. It failed to identify whether R37 consented or refused administration of the vaccine, and if refused, the reason why.</p> <p>During an interview on 8/4/15 at approx 11:00 AM, R37 stated that she had the pneumococcal vaccine approximately three (3) years ago.</p> <p>The facility failed to obtain information from R37, who was alert and oriented, regarding the status of her pneumococcal vaccine, and failed to ensure that the clinical record was complete.</p> <p>Findings were reviewed with E2 (DON) and E14 (RDH) on 8/4/15 at approximately 11:30 AM.</p> | F 514 | <p>3. All new admissions will be provided the consent form to give them an opportunity to consent or decline the immunization. This will be reviewed at the clinical meeting, to ensure that the authorization was provided. The Staff Development Coordinator will in-serviced all licensed staff on providing the immunization authorization form upon admission. Training will provided annually and upon new hire orientation.</p> <p>4. The Director of Nursing or designee, will audit all new admissions for pneumococcal documentation of the authorization form, weekly, times four (4) weeks, until 100%, then monthly, times two (2), until 100%. The QAPI team will then review all findings and identify trends to determine a need for continued audits.</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: Five Star Faulk Manor North Nursing Home

DATE SURVEY COMPLETED: August 4, 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>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from July 29, 2015 through August 4, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 45. The Stage 2 survey sample size was 24.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed August 4, 2015 F225, F272, F278, F280, F309, F315, F323, F329, F371, F431, F502 and F514</p> | <p>Responses to the cited deficiencies do not constitute an admission of agreement by Faulk Manor North of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.</p> <p>Cross refer to the CMS 2567-L survey completed August 4, 2015, F225, F272, F278, F280, F309, F315, F323, F329, F371, F431, F502 and F514</p> | <p>9/10/2015</p> |

Provider's Signature *Virginia C. Gray* Title *Executive Director* Date *September 2, 2015*