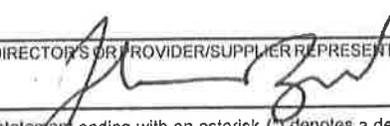


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2015
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from May 26, 2015 through June 5, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 157. The survey sample totaled 44.</p> <p>Abbreviations used in this 2567 are as follows: NHA- Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM- Unit Manager; MD - Medical Doctor; RNAC- Registered Nurse Assessment Coordinator; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); CNA - Certified Nurse's Aide; ADL - Activities of Daily Living, such as bathing and dressing; mg- milligrams; Restorative Nursing Program (RNP) - restorative nursing interventions promote the resident's ability to adapt and adjust to living as independently and safely as possible; PT- physical therapy; FSBS - finger stick blood sugar; MAR - Medication Administration Record; Urinary incontinence- inability to prevent accidental leakage of urine from bladder; Urinary continence - ability to prevent accidental leakage of urine from bladder; Sliding scale - Physician's orders to give insulin injections based on FSBS reading;</p>	F 000	<p>Submitted Plan of Correction for survey ending June 5, 2015.</p> <p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law</p>	

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



TITLE
Administrator of Record

(X8) DATE
7/7/2015

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 POS - Physician's Order Sheet; Insulin - medication injected under the skin to lower blood sugar level.	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on multiple observations it was determined that the facility failed to promote care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>During lunch observations on 5/26/15, several CNA's were observed bringing lunch trays into the rooms of 14 residents (R15, R16, R18, R47, R64, R74, R81, R131, R163, R165, R202, R207, R249, and R250) without asking/waiting for permission to enter after knocking or not knocking or asking permission to enter at all. Additionally, R240 was fed in her room and the CNA had very little interaction with the resident during feeding. Findings include:</p> <p>During lunch observations in the Henlopen halls on 5/26/15 from 12:33 PM to 1:00 PM the following were observed while trays were being passed:</p> <p>1. E11 (CNA) entered the resident rooms of R250 and R207 - knocked and entered without asking for permission to enter;</p>	F 241	<p>A. R15, R16, R18, R47, R64, R74, R81, R131, R163, R165, R202, R207, R240, R249, and R250 were affected by this practice.</p> <p>B. All resident in the facility has the potential to be affected by the practice.</p> <p>C. The Staff Developer/designee will educate all staff on Residents Rights and Dignity using in-service tool, specifically focusing on door knocking and waiting for permission to enter. The Staff Developer/designee will educate licensed nursing staff on proper meal and dining delivery practices as it relates to dignity.</p> <p>D. The Director of Nursing (DON) /designee will conduct an audit at meal times daily until 100% compliance is achieved through the use of a specific audit tool (Attachment A). Then, the DON / designee will conduct an audit 3 times per week at meal times to ensure 100% compliance is maintained. Then, DON / designee will conduct an audit one time per week at each meal to ensure 100% compliance is maintained. Finally, the DON / designee will conduct an audit one month later at meal times to ensure 100% compliance has been maintained. The results of the audits will be reviewed at the Quality Assurance (QA) meeting and presented to the committee for review and compliance.</p>	8/14/2015

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F 241	Continued From page 2 2. E12 (CNA) entered the room of R202- knocked and entered without asking for permission to enter; 3. E13 (CNA) entered the rooms of R64 and R249- knocked and entered without asking permission to enter; 4. E14 (CNA) entered the rooms of R131 and R15- knocked and entered without asking permission to enter; 5. E15 (CNA) entered the rooms of R74, R165, R163, and R16- she knocked and entered without asking permission to enter; 6. E16 (CNA) entered the rooms of R81, R47 and R18 without knocking or asking permission to enter. Findings were reviewed with E1 (NHA) and E2 (DON) during the informational meeting on 6/4/15 at approximately 4:10 PM. 7. E20 CNA, was feeding R240 on 5/26/2015 at 12:43 PM. The CNA provided little interaction with the resident and did not ask the resident what foods were preferred or what was available. These findings were reviewed with E1 and E2 on 6/5/15 at 10:15 AM.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			

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F 253	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to maintain housekeeping and maintenance services on all three units of the facility. Findings include:</p> <p>On May 29, 2015 from 1:30-3:00 PM, during the environmental tour, the following findings were identified:</p> <ol style="list-style-type: none"> Shower tiles/floors were stained in the following rooms - 105, 107, 303, 350, and 354. Bathroom floors were stained in rooms - 205, 250, and 252. Rooms that required maintenance due to damage or unpainted spackling - 350 bathroom and bedroom, 360 bathroom, 366 bathroom, 208 above outlet near bed A, 211 wall near bed A, 212A wall, 250 across from bed A, 260 across from beds, 355 bathroom, shower room on Sussex, and the chair rail in Lighthouse (Lewes) dining room. Furniture damage - 259 bedside stand and 260 top of small dresser. The floor was cracked and scratched in room 304. The wound care cart and medication storage countertops were stained in the Lewes unit. The medication storage countertop in the Sussex unit was stained. 	F 253	<ol style="list-style-type: none"> Residents in rooms 105, 107, 303, 350, 354, 205, 250, 252, 360, 366, 208, 211, 212, 260, 365, 259, 304, 204, 251, 245(A-bed), 302, 305 (A-bed), 367 (A-bed) all Residents who use the shower room on the Sussex Unit, and all resident on Lewes Unit. Items 1, 2, 3, 4, 8, and 9 were addressed by Maintenance and environmental services by adjusting the chemical formulary and / or completing the repair during after the tour, before the survey team exited. A full building sweep was conducted immediately for any other type of occurrences, and none were found. (Attachment Q) Every resident in the facility has the potential to be affected by the practice. Items 5, 6, and 7 will be replaced within 45 days. Survey team was provided with 12 month capital program for flooring, fixtures, and equipment that will address long term improvements. Nursing Home Administrator (NHA) and Maintenance Director will educate Maintenance staff on the immediate inspections of rooms All items mentioned during tour have been added to preventative maintenance list, and will be reviewed monthly during rounds, and quarterly during QA for compliance. Evaluation success will be determined having 100% of addressed items monitored for compliance under the monthly and quarterly preventative maintenance report. Status will be shared in QA (Attachment R). 	8/14/2015	

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F 253	Continued From page 4 8. The shower chair in the Sussex shower room was stained. 9. Overbed light cords missing or short in rooms- 204, 251, 254A, 260B, 302, 305A, 355A, 360, 365B, 366A, and 367A. An interview was conducted at the conclusion of the environmental tour with E1 (NHA) and E9 (Maintenance Supervisor) to confirm these findings. These findings were reviewed with E1 and E2, DON on 6/5/15 at 10:15AM.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	A. The Minimum Data Set (MDS) was clarified for R97 upon notification of the practice (Attachment B). B. Every resident in the facility has the potential to be affected by the practice. A focus review of urinary status on the MDS was conducted on all residents admitted in the last 30 days for accuracy of coding. No further coding errors were found. C. The Staff Developer/designee will educate the 2 staff Registered Nurse Assessment Coordinator (RNAC)'s at the facility on proper coding on the MDS in urinary continence.	8/14/2015

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F 272	<p>Continued From page 5</p> <p>Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct a comprehensive, accurate, standardized reproducible assessment for 1 (R97) out of 44 stage 2 sampled residents. The facility failed to conduct an accurate significant change MDS, dated 4/3/15, for urinary incontinence for R97. Findings include:</p> <p>Review of R97's Admission/5 Day MDS assessment, dated 3/17/15, revealed she was frequently incontinent of urine (7 or more episodes, but at least 1 episode of continent voiding). The following MDS, a significant change, dated 4/3/15, coded R97 as always incontinent of urine (no continent episodes) indicating a decline in urinary status.</p> <p>Review of CNA Caretracker Sheets from 3/28/15 through 4/3/15 (7 day look back period used to determine R97's urinary incontinence on the 4/3/15 significant change MDS) was inaccurate. R97 had 2 episodes of urinary incontinence during the look back period, therefore, she remained frequently incontinent of urine and did not decline in urinary status.</p>	F 272	<p>D. The DON/designee will conduct an audit daily of all MDS urinary continence assessment and coding until 100% compliance is achieved (Attachment C). Then, the DON/designee will conduct an audit 3 times per week of MDS urinary continence assessment and coding to ensure 100% compliance is maintained. Then, the DON/designee will conduct and audit one time per week of MDS urinary continence assessment and coding to ensure 100% compliance is maintained. Finally, the DON/designee will conduct a final audit one month following of MDS urinary continence assessment and coding to ensure 100% compliance has been maintained. The results of the audits will be reviewed at the QA meeting and presented to the committee for review and compliance.</p>	

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F 272	Continued From page 6 E21 (RNAC) was interviewed on 6/2/15 at 2 PM and confirmed the findings. Findings were reviewed with E1 (NHA) and E2 (DON) during the informational meeting on 6/4/15 at approximately 4:20 PM.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop a comprehensive care plan for 1 (R97) out of 44 sampled stage 2 residents. The facility failed to develop a RNP care plan for R97. Findings include:	F 279	A. R97 was impacted by the practice; cross refer to F-311. A restorative nursing care plan was implemented upon starting the restorative nursing program on 06/05/2015. (Attachment D) B. All residents on the restorative nursing plan and potential new residents referred to the restorative nursing program have the potential to be affected. A focused review was immediately conducted upon discovery of the practice to insure that all residents on the restorative program had a care plan in place. C. The discharging therapist will make the referral to the restorative nursing program as indicated on the restorative nursing referral form. Once the referral is made, the Rehab Director / Designee will review the referral form with the restorative aide. Training will be provided to the restorative aide as necessary. Once the restorative aide has verified understanding for specific training the referral form will then go the Unit Manager or charge nurse of the unit that the resident resides. The referring therapist will then write the restorative nursing order in the chart. The Unit manger or charge nurse will then create the restorative nursing documentation sheet and develop the restorative nursing care plan. Weekly all residents on the restorative nursing program as well all new referrals for that week will be reviewed for timely implementation of the program and well as the development of a care plan.	8/14/2015

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F 279	<p>Continued From page 7</p> <p>Cross refer to F311</p> <p>Record review revealed that R97 was hospitalized twice in March 2015, the latter hospitalization was for surgical repair of a broken hip. R97 was readmitted to the facility on 3/27/15.</p> <p>Review of the Physical Therapy Discharge Summary, dated 5/27/15, revealed that R97 received PT services from 3/27/15 through 5/20/15. Discharge recommendations included implementation of a RNP.</p> <p>Review of the RNP Resident Plan, dated 5/22/15, listed the problem as potential for decreased ambulation.</p> <p>Review of physician orders, dated 5/22/15, stated that PT services were discontinued on 5/20/15 and R97 was referred to RNP for continued ambulation.</p> <p>Review of R97's care plan on 6/2/15 revealed that the facility failed to initiate a care plan for the RNP ordered on 5/22/15.</p> <p>E26 (UM) was interviewed on 6/2/15 at 11:45 AM. After reviewing R97's care plan, E26 confirmed that the facility failed to care plan for the RNP ordered on 5/22/15.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the informational meeting on 6/4/15 at approximately 4:15 PM.</p>	F 279 D.	The Rehabilitation director will communicate with the DON when a new referral is made to the restorative nursing program. The DON / Designee will audit every new referral and existing resident on the restorative nursing program until 100% compliance is achieved (Attachment E). Then, the DON / designee will conduct a weekly audit during the focus review to ensure 100% compliance is maintained. This audit will be ongoing as a revision to the program as stated above. The results of the audit will be reviewed and presented the QA committee for review and compliance.	

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F 309 SS=E	<p>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 review and interview it was determined that for 2 (R85 and R213) out of 44 stage 2 sampled residents the facility failed to follow the physician's plan of care. For R85 the facility failed to follow the physician's order for FSBS for almost a 4 month period. For R213 the facility failed to follow the facility's policy and plan of care pertaining to pain management. Findings include:</p> <p>1. R85 had a diagnoses of Diabetes (disease causing elevated blood sugars).</p> <p>Re-admission orders from the hospital dated 2/3/15 documented FSBS 4 times a day for 3 days then resume the previous twice a day schedule for FSBS. Additional documentation included the Novolog (Insulin) subcutaneous (injection in skin) 4 times a day per sliding scale for 3 days, then resume previous twice a day schedule.</p> <p>Review of the MARs from 2/3/15 through 5/28/15 documented that R85 had FSBS done 4 times a day with Insulin coverage per the sliding scale.</p>	F 309	<p>1.)</p> <p>A. The Medical Doctor (MD) order for R85 was corrected before the information was brought to the DON and NHA's attention.</p> <p>B. All residents have the potential to be affected by the practice. A focus review was conducted upon discovery of the deficient practice on all Residents with insulin and finger stick orders and were verified as accurate.</p> <p>C. The Staff Developer / designee will educate the licensed nurses on night shift on the 24 hour chart check process. The night shift nurse will perform a 24 hour chart check on all new admissions, readmissions, and new orders written by the MD in the last 24 hours. The new admission orders will be reviewed for accuracy a second time the following day.</p>	8-14-2015

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F 309	<p>Continued From page 9</p> <p>The March, April and May 2015 Physician Order Sheets included an order originating 9/8/14 for FSBS two times a day with SS (sliding scale). There was also an order originating 2/4/15 for Novolog inject subcutaneously 2 times a day per sliding scale.</p> <p>On 5/28/15 the physician ordered to discontinue the 12:00 PM and 5:00 PM blood sugars and sliding scale Insulin and to start Metformin (oral diabetic medication) daily.</p> <p>An interview on 6/4/15 at 2:01 PM with E23 (MD) revealed that on 5/28/15 he decreased the frequency of the FSBS from 4 times a day to 2 times a day at the request of nursing who reviewed with him the resident's blood sugars that had become more stable. He also added an oral diabetic medication and stated he was not aware of an order in February to decrease the FSBS to twice a day. E23 stated there would be no negative effect to the resident related to the additional blood sugar monitoring and insulin coverage.</p> <p>For almost a 4 month time period R85 had FSBS 4 times a day although the current physician order was for 2 x's day.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 6/5/15 at 10:15 AM.</p>	F 309 D.	<p>The DON/designee will conduct an audit of all new admissions for accuracy of transcription of medication orders until 100% compliance is achieved (Attachment F). Then, the DON/designee will conduct an audit of new admission and orders written by the MD in the last 24 hours 3 times per week to ensure 100% compliance is maintained. Then, the DON/designee will conduct an audit of new admission orders and orders written in the last 24 hours weekly to ensure 100% compliance has been maintained. Finally, the DON/designee will conduct an audit one month later of new admission orders and orders written by the MD in the last 24 hours to ensure 100% compliance has been maintained. The results of the audit will be reviewed and presented to the QA committee for review and compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
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F 309	<p>Continued From page 10</p> <p>2. The facility's Pain Management Guidelines documented that residents receiving routine and as needed pain medications will have pre and post score documentation recorded on the medication administration record. It went on to say that a numeric pain scale would be used for residents who are alert and oriented. The policy also stated that the staff will evaluate the effectiveness of medication administration to evaluate further interventions.</p> <p>R213 had a physician's order originating 9/12/14 for Tramadol (pain medication) 50 mg two tablets every 6 hours as needed. The resident also had an order for Acetaminophen/APAP (pain/fever medication) 325 mg give 2 tablets every 4 hours as needed for mild pain.</p> <p>The resident's care plan dated 4/11/14 for potential for pain related to generalized aches and arthritis last revised on 1/7/15, documented that pain will be at a controlled level that is comfortable to resident through review date. With approaches that included;</p> <ul style="list-style-type: none"> -use pain scale when assessing for pain both before and after medication administration -administer pain medication as per MD orders and note the effectiveness -acknowledge presence of pains and discomfort. Listen to resident's concerns. <p>Review of the resident's monthly pain assessment for 4/2015 and 5/2015 documented that R213's pain was a 2 on a 0 - 10 scale.</p> <p>Review of the resident clinical record revealed the following:</p>	F 309	<p>2.)</p> <ul style="list-style-type: none"> A. R213 was affected by the practice. A reassessment of R213's acceptable pain level was conducted. Verification of the Medication Administration Record (MAR) was completed for pre and post pain assessment for all routine and <i>Pro Re Nata</i> [Latin for "when necessary"] (PRN) medication (Attachment G). B. All residents have the potential to be affected by the practice. A focus review was conducted to audit all resident's acceptable level of pain score, pain management regime, pain scale in use, and effectiveness of pain management regime for the entire census during survey. C. The Staff Developer/designee will educate licensed nurses on the pain management program. Upon admission, readmission, quarterly and annually and with a significant change, each resident will have a pain assessment completed. An acceptable level of pain will be determined at this time as well as the accurate pain scale to be used to assess pain in each resident. The pain management regime will be reviewed by the MD/Nurse Practitioner (NP). For each pain medication administered a pre- and post- pain scale score will be assessed and recorded for effectiveness. The medication administration record will be reviewed by the MD for effectiveness of the pain management regime. 	8-14-2015

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F 309	<p>Continued From page 11</p> <p>Post pain scale did not meet the resident's goal and no additional interventions were noted;</p> <p>-4/13/15 Tramadol 50 mg 2 tabs at 5:30 PM for 10/10 BLE (bilateral lower extremity) and back pain with positive effect of 7/10 at 6:30 PM.</p> <p>-5/14/15 Tramadol 100 mg 8 PM for left hand pain 10/10 with positive effect of 9/10 at 9 PM</p> <p>-5/22/15 APAP 650 mg at 9:50 PM for headache 8/10 with positive effect at 10:50 PM of 6/10</p> <p>-5/29/15 APAP 650 mg at 10:30 PM for back pain 9/10 with positive effect of 8/10 at 11:30 PM</p> <p>Review of the record lacked evidence of any further assessment and/or interventions for pain when the post scale was higher than the resident goal.</p> <p>The same numeric pain scale was not used before and after medication administration;</p> <p>-4/11/15 APAP 650 mg at 4:10 PM for toe and back pain at 10/10 with positive effect at 6:10 PM no post scale used.</p> <p>-4/18/15 APAP 650 mg at 10:40 PM for head ache with positive effect at 12:00 AM no scale used before or after.</p> <p>-5/3/15 4 AM Tramadol 100 mg for pain/generalized with result sleeping at 4:20 AM no pain scale used before or after.</p> <p>-5/4/15 5:15 PM Tramadol 50mg for 10/10 generalized pain no result documented for 6:15 PM entry</p> <p>-5/10/15 4:30 PM Tramadol 100 mg for 10/10 with + effect at 6 PM no post pain scale.</p> <p>-5/22/15 Tramadol 100 mg at 4:45 AM for general pain 8/10 with no results.</p> <p>-5/22/15 APAP 650 mg at 5:00 PM for headache 4/10 with positive effect no post scale.</p> <p>-5/31/15 Tramadol 100 mg at 6:30 AM for general pain 8/10 no results noted.</p>	F 309	D.) The DON/designee will conduct an audit of the medication administration record daily for an acceptable level of pain, current pain regime, an established pain scale, and effectiveness of current pain regime until 100% compliance is achieved (Attachment H). Then, the DON/designee will conduct an audit 3 times per week to ensure 100% compliance is maintained. Then, the DON/designee will conduct an audit weekly to ensure 100% compliance is achieved. Finally, the DON/designee will conduct an audit one month later to ensure 100% compliance is maintained. The results of the audit will be reviewed and presented to the QA committee for review and compliance.	

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F 309	Continued From page 12 An interview on 6/03/15 at 11:32 AM interview with E22, LPN revealed she had no further information about the pain assessments. She confirmed a numeric scale should be used before and after administration for this resident. These findings were reviewed with E1 and E2 on 6/5/15 at 10:15 AM.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide the appropriate treatment and services to maintain or improve 1 (R97) out of 44 stage 2 sampled resident's abilities. As of 6/2/15, 11 days after a daily RNP was ordered for R97, the facility failed to initiate the RNP after PT services were discontinued. Findings include: The Nursing Policy entitled Restorative Care Program, dated 1/3/2008 with an effective date of 3/3/2008, stated, "... ADON/Designee is responsible for the coordination and oversight of the restorative program... Rehab Department, Unit Manager, Licensed Nurse or other members of the Interdisciplinary Team will refer residents to the restorative Program... ADON/Designee and Unit Managers are responsible for accepting the	F 311	A. R97 was impacted by the practice; cross refer to F-279. The restorative nursing meeting was held on 6/3/2015 and R97's restorative nursing program was implemented on this date (Attachment I). B. All residents on the restorative nursing plan and potential new residents referred to the restorative nursing program have the potential to be affected. C. The discharging therapist will make the referral to the restorative nursing program as indicated on the restorative nursing referral form. Once the referral is made, the Rehabilitation Director/designee will review the referral form with the restorative nursing aide. Training will be provided to the restorative aide as necessary. Once the restorative aide has verified their understanding of the plan, the referral form will then go to the Unit Manager or charge nurse of the unit that the resident resides. The referring therapist will then write the restorative nursing order in the chart. The Unit manager or charge nurse will then create the restorative nursing documentation sheet and develop the restorative nursing care plan. Weekly all residents on the restorative nursing program as well as all new referrals for that week will be reviewed for timely implementation of the program and well as the development of a care plan.	8-14-2015

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F 311	<p>Continued From page 13</p> <p>resident into the restorative program. A restorative referral form will be completed and forwarded to the ADON/Designee. Problems, goals and interventions will be developed and documented on the resident's care plan by the Rehab Department... Care plans will be updated when the resident is accepted into the program and as needed... Flow sheets will be used to document interventions. Restorative programs must be provided at least 15 minutes per day, at least 6 days a week... When Rehab assists in the development of an individual restorative program, they will forward recommendations to the ADON/Designee. Rehab will in-service restorative aides who will then in-service C.N.A.'s."</p> <p>Record review revealed that R97, a 93 year old resident was hospitalized twice in March 2015, the latter hospitalization was for surgery to repair a broken hip after a fall. R97 was readmitted to the facility on 3/27/15.</p> <p>Review of the Physical Therapy Discharge Summary, dated 5/27/15, revealed that R97 received PT services from 3/27/15 through 5/20/15. Discharge recommendations included implementation of a RNP for wheel chair mobility, transfers and ambulation (walking).</p> <p>Review of the RNP Resident Plan, dated 5/22/15, listed the problem as potential for decreased ambulation and an individualized daily program was developed for R97.</p> <p>Review of physician orders, dated 5/22/15, stated that PT services were discontinued on 5/20/15 and R97 was referred to RNP for continued ambulation.</p>	F 311	<p>D. The Rehab director will communicate with the DON immediately when a new referral is made to the restorative nursing program. The DON/designee will audit every new referral and existing residents on the restorative nursing program until 100% compliance is achieved(Attachment E). Then, the DON/designee will conduct a weekly audit during the focus review to ensure 100% compliance is maintained. This audit will be ongoing as a revision to the program as stated above. The results of the audit will be reviewed and presented the QA committee for review and compliance.</p>		

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F 311	<p>Continued From page 14</p> <p>Record review revealed a lack of evidence of the RNP ordered on 5/22/15.</p> <p>Review of the unit Restorative book revealed lack of a RNP for R97.</p> <p>Observations of R97 were done on 5/28/15, 5/29/15 and 6/2/15 at various times, including late morning and afternoons. R97 was in bed for all observations.</p> <p>E28 (Rehabilitation Office Coordinator) was interviewed on 6/2/15 at 11:35 AM. E28 provided a copy of the RNP ordered for R97 on 5/22/15 and stated it was signed by E29 (Restorative Aide) on 5/27/15, which is considered the order date of the RNP. E28 stated after E29 signed the RNP, a copy was sent to E2 (DON) and a care plan would be developed before the RNP starts.</p> <p>E26 (UM) was interviewed on 6/2/15 at 11:45 AM. After reviewing R97's record and the Restorative book, E26 confirmed there was no RNP in R97's record or the Restorative book. E26 also stated R97 lacked a care plan for a RNP which would include the contents of the RNP as recommended by PT. Additionally, E26 stated there were usually 2 restorative aides, but 1 was out on leave.</p> <p>E2 was interviewed on 6/2/15 at 11:50 AM. E2 stated she received a copy of R97's RNP, however, the facility meets once a week, usually on Wednesdays depending on the schedule and the restorative caseload is reviewed and a care plan is initiated. E2 confirmed that the facility had not yet met to review R97's RNP.</p>	F 311			

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F 311	Continued From page 15 E29 (Restorative Aide) was interviewed on 6/2/15 at 11:55 AM. E29 stated she did not start the RNP ordered on 5/22/15 for R97 because she has to wait until E2 advises her and places a copy of the RNP in the Restorative Book. The facility failed to provide the RNP ordered on 5/22/15 as of 6/2/15, 11 days later. The RNP was to start after completion of PT to attain or improve R97's abilities in wheel chair mobility, transfers and ambulation. Findings were reviewed with E1 (NHA) and E2 during the informational meeting on 6/4/15 at approximately 4:25 PM.	F 311		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that one (R170) out of 44 sampled residents had the assistive devices necessary to prevent accidents. The facility also failed to ensure all three units of the building were free from accident hazards. Findings included: 1. R170's annual MDS dated 4/14/15 documented two or more falls with no injury since the last review (90 days).	F 323	1.) A. R170 was impacted by this practice. Non-skid strips were immediately confirmed placed or added to assure that both beds and both sides had the non-skid strips upon notification of the practice. (Attachment Q) B. Some residents, using non-skid strips, have the potential to be affected by the practice. An immediate audit was conducted through the entire facility to examine any Residents that may have non-skid strips as part of their care plan, and that they were on both sides of their bed. A further immediate audit identified if any Resident with a non-skid strip as part of their care plan share a room that was not occupied and there was a potential for the Resident to self select the vacant bed. There were no deficiencies found in any other rooms, beds or for any Residents.	8-14-2015

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F 323	<p>Continued From page 16</p> <p>The facility documented falls 3/22, 3/31 (twice), 3/28, 5/16, and 5/21/15. All with no injury. For three of the six falls the resident was found next to the bed.</p> <p>The resident's care plan originating on 5/14/13 and last revised on 4/16/15 for at risk for falls included the approach of non-skid strips to the right side of the bed that was noted as having been added on 5/3/14.</p> <p>Observations of the resident during the survey revealed the following;</p> <p>-6/1/15 around noon in wheelchair eating lunch in room. Non-skid strips noted to left side of bed closest to the window, resident sitting near door.</p> <p>-6/2/15 11:30 AM laying on bed closest to door with eyes closed. Legs hanging off left side of bed. Wheelchair next to left side of bed. No non-skid strips to either side of bed</p> <p>-6/2/15 1:49 PM the resident was in wheelchair just outside the room and stated he sleeps in the bed closest to the door.</p> <p>-6/3/15 10:24 AM resident in bed closest to the door. No non-skid strips on floor.</p> <p>An interview on 6/2/15 at 1:56 PM with E5, CNA revealed that the resident self-transfers to bed even though he is supposed to call for help. She also stated that R170 used to sleep in the bed by the window but for the past 3-4 months he has been sleeping in the bed closest to the door. She further stated the resident often gets out on the left side of the bed.</p>	F 323	<p>C. The Staff Developer/designee will educate licensed nursing staff on the fall management program. A fall risk assessment will be conducted on Admission, Quarterly, Annually, Significant change, and with any fall that occurs. Based on the fall risk assessment, safety interventions will be implemented and a care plan for falls and safety will be implemented. The interdisciplinary fall review team will conduct a fall review after each fall to determine factors affecting the fall and safety devices will be implemented accordingly.</p> <p>D. The DON/designee will conduct an audit of newly implemented safety devices daily to ensure they are in place and appropriate until 100% compliance is achieved (Attachment J). Then, the DON/designee will conduct an audit of newly implemented safety devices 3 times per week to ensure 100% is maintained. A similar maintenance audit will continue, in tandem, until 90 days of 100% compliance is obtained (Attachment S) Then, the DON/designee will conduct an audit of newly implemented safety devices one time per week to ensure 100% compliance is maintained. Finally, the DON/designee will conduct an audit one month later to ensure 100% compliance has been maintained. The results of the audits will be presented and reviewed by the QA committee for review and compliance.</p>		

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F 323	Continued From page 18 4. On May 29, 2015, 1:30-3:00 PM all resident bathrooms had a canister of blue liquid attached to the toilet. This product was not labeled and presented a potential safety hazard. It was later identified in an e-mail on June 10, 2015 from E1, NHA as a product called Quat Disinfectant Cleaner. An interview conducted with E1 and E9 Maintenance Supervisor, on May 29, 2015 during and after the environmental tour confirmed the above findings.	F 323	C. Environmental services was and will be permanently provided a stock of plastic caps to accompany their service carts, while treating the bathroom floor if a cap is missing, it will be replaced during the service time. D. A specific line item will be added for the monthly room inspections form for the caps. Weekly, the rooms will be inspected for the caps until a 100% compliance is achieved for 90 consecutive days. Upon successful completion of the 90 day period and with confirmation from QA, the weekly audits will resume to the monthly permanent audit. (Attachment S)	8-14-2015
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - A. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and B. Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: During a kitchen tour on 5/26/15 from 11:30 AM - 12:30 PM the following was observed: -A hand washing area near the mechanical dish washer lacked a splash guard protecting the clean dishes from being contaminated during hand washing.	F 371	4.) A. Upon reporting of the practice a whole house audit was conducted, only 29 bathrooms of the 101 Resident bathrooms and 7 common area bathrooms had an attached bottle. Of the 29 bottles only 17 has a chemical in them. The chemical could only be utilized with a two step lever control. (Attachment Q) B. All Residents could have been affected by the practice. C. All bottles were removed permanently. Caps have been purchased to seal previous connections. D. Presence of a toilet-flush-with-an-assisted-arm-disinfectant-cleaner will no longer be present or at risk to be used. A. No residents had been impacted by the practice. (Attachment Q) B. All residents could be impacted by the practice	8-14-2015

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F 371	Continued From page 19 -During the inspection of the food prep sink and the ice machine, the air gap between the affluent drainage pipe and the flood line was not adequate. -A dish rack was observed blocking the manager's office side of the hand sink making the hand sink difficult to operate. This can be a deterrent for food facility employees to wash hands at the location. The tour was conducted with the Regional Food Service Director E27 who observed the above findings. These findings were reviewed with E1, NHA and E2, DON on 6/5/15 at 10:15AM.	F 371 C.	The inspection findings were repaired as such: i. Redundant Hand Washing sink was eliminated. Existing hand washing sink, had no such issues. Sink was previously used for a satellite kitchen service that is no longer functioning on campus. ii. Air gap was adjusted to the measurements provided by the inspector. All other devices met the measurements. iii. Sink similarly identified above in item (i.) was removed. Existing hand washing sink, had no such issues. Sink was previously used for a satellite kitchen service that is no longer functioning on campus. D. Air gap measurements will be added to the monthly inspection for the kitchen and reported at QA, showing any variations requiring repair was reported and fixed within 72 hours. (Attachment U)		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:				

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NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
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F 428	<p>Continued From page 20</p> <p>Based on record review and interview it was determined that for 5 (R92, R73, R137, R170 and R85) out of 44 sampled residents the facility failed to ensure drug regimen reviews were conducted monthly by the pharmacist. It was further determined that no residents in the facility had drug regimen reviews completed in September 2014. Findings include:</p> <ol style="list-style-type: none"> 1. Review of R92's clinical record revealed that the Consultant Pharmacist Review was missing documentation for September 2014. 2. Review of R73's clinical record revealed that the Consultant Pharmacist Review was missing documentation for September 2014. 3. Review of R137's clinical record revealed that the Consultant Pharmacist Review was missing documentation for September 2014. 4. Review of R170's clinical record revealed that the Consultant Pharmacist Review was missing documentation for September 2014. 5. Review of R85's clinical record revealed that the Consultant Pharmacist Review was missing documentation for September 2014. <p>An interview on 6/02/2015 at 11:33 AM with E2, DON confirmed that the September 2014 Consultant Pharmacist Reviews were not done for any of the residents in the facility. She further revealed that the pharmacist with their contract company was out on unexpected medical leave in September 2014 and the pharmacy did not send a pharmacist in to do the September review.</p>	F 428	<p>A. All residents in the facility were potentially affected by the practice however no adverse effects were found or reported by the practice.</p> <p>B. All residents in the facility could be affected by the practice.</p> <p>C. The pharmacy consultant will be provided a facility census upon entrance into the facility to conduct the monthly review. The pharmacy consultant will cross reference census with actual reviews to ensure all resident are reviewed. Pharmacy recommendation forms will then be given to the DON/designee as a second check to ensure all residents were reviewed.</p> <p>D. The Pharmacy Director/designee will audit compliance ensuring each resident in the facility has had a monthly review completed on a monthly basis for 3 consecutive months until 100% compliance is achieved. Then, quarterly for 3 quarters to ensure 100% compliance is maintained. The results of the audits will be present and reviewed by the QA committee for review and compliance. (Attachment X)</p>	8-14-2015

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F 431 SS=D	<p>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 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 accurately label and remove expired medications to facilitate the safe administration of medications.</p>	F 431	<p>A. No Resident was harmed by this practice; and an immediate review was conducted to check for expired medications in the medication carts and back up medications upon discovery of the practice and no further medications were found to be expired.</p> <p>B. All residents have the potential to be affected by the practice.</p> <p>C. The DON obtained the pharmacy guidelines of medication shelf life and administration. The staff developer/designee will educate licensed nurses on the guideline from pharmacy of medication shelf life. The medication carts will be audited by the night shift licensed nurses for expired medication weekly to ensure medications are discarded that are expired.</p> <p>D. The DON/designee will conduct an audit 3 times per week of medication carts and back up medication until 100% compliance is achieved (Attachment K). Then, the DON/designee will conduct an audit weekly to ensure 100% compliance has been maintained. This weekly audit will be ongoing for 3 months to ensure 100% compliance has been maintained. The results of the audits will be reviewed and presented to the QA committee for review and compliance.</p>	8-14-2015

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F 431	Continued From page 22 1. On 5/26/15 at 10:20 AM the medication cart for the even room numbers on the front hallway of the Henlopen Unit had a card of Senexon-S (medication to promote bowel movement) containing 30 tablets with an expiration date of 5/4/15. This finding was confirmed with E17 (LPN) at 10:25 AM. 2. On 5/28/15 at 11:30 AM the medication cart for Cape Avenue on the Lewes Unit had a stock bottle of Ibuprofen (anti-inflammation medication) that was open but was not marked with the date it was opened. 3. On 5/28/15 at 11:35 AM the medication cart for Cape Avenue on the Lewes Unit had a stock bottle of Kaopectate (medication for mild loose stools) that was opened and dated 3/28/2015. E19, LPN stated that according to facility policy, medications should be discarded after being open for 30 days. These findings were confirmed with E19 at 11:50 AM. These findings were reviewed with E1, NHA and E2, DON on 6/5/15 at 10:15 AM.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441			

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F 441	<p>Continued From page 23</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it-</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to administer medications in a sanitary manner by touching oral medications with bare hands and failing to perform hand hygiene before administering medications to 3 (R12, R107, R170) out of 3 residents observed receiving medications.</p>	F 441		

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F 441	<p>Continued From page 24</p> <p>During medication administration on 5/28/15 between 7:56 AM - 8:08 AM the following findings were observed:</p> <ol style="list-style-type: none"> E18, LPN, placed a glucometer (machine to measure blood sugar using a drop of blood from a resident's finger) in storage, stating "I just finished my fingersticks". E18 immediately reviewed the pages of R107's MAR, removed the medication cards from the medication cart and pushed the pills directly into a medicine cup. The nurse took the medication cup to the resident's bedside without first performing hand hygiene (wash hands with soap and water or rub alcohol foam/gel on hands and allow to dry). When R107 dropped two pills onto the bed linens, E18 picked up the pills with a contaminated bare hand and placed them back into the medicine cup. R107 took these medications. E18 signed off (wrote initials) on the MAR for each drug administered to R107 then immediately reviewed the pages of the next resident's (R12) MAR. E18 removed one medication card from the medication cart and pushed a capsule directly into a medication cup. The nurse carried the medication cup to R12's bedside without first performing hand hygiene. After R12 took the medication, E18 returned to the medication cart to sign off the administration on the MAR then immediately reviewed the pages of the next resident's (R170) MAR. E18 removed the medication cards from the medication cart and pushed R170's medications directly into a medicine cup. The nurse went to R170's bedside without first performing hand hygiene. 	F 441	<ol style="list-style-type: none"> R12, R107, and R170 were affected by the practice. All residents have the potential to be affected by the practice. The staff Developer/designee will educate licensed nurse on the standard of practice of medication administration and infection control standard of practice. The Staff developer/designee will conduct a medication pass observation on all licensed nurses in the facility for competency. Then, the staff developer/designee will conduct a medication pass observation quarterly on licensed nurses to ensure competency has been maintained (Attachment L). Any licensed nurse found to have an unsatisfactory medication pass observation will receive focused training with the staff developer to ensure compliance. Then, the licensed nurse will receive a medication pass observation before returning to the floor to administer medications independently. 	8-14-2015

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F 441	Continued From page 25 E18 put on disposable gloves to help the resident to a seated position in bed, then removed the gloves to hand the medication cup to R170. The resident had difficulty removing the pills from the medicine cup so E18 supported the resident upright with a contaminated bare hand. After the resident took the medications, E18 did perform hand hygiene by washing hands with soap and water. E18 did not perform hand hygiene prior to medication administration for three (R12, R107, R170) residents. These findings were reviewed with E1, NHA and E2, DON on 6/5/15 at 10:15 AM.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM- ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for 4 out of 39 rooms reviewed during Stage 1 observations, the facility failed to ensure the bathroom call bells were properly functioning. Findings include: During room tours on 5/27/15 around 2:00 PM it was noted the call bells in the bathroom of rooms 305, 306, 310 and 259 were wrapped around the handrail. This resulted in the call bell not functioning when the pull cord was activated from below the handrail.	F 463	A. 8 Residents (4 rooms) were identified for being at risk for this deficient practice. All Bathroom call light cords were freed from toilet support arms in rooms 305, 306, 310, and 259. (Attachment Q) B. All Residents could potentially be affected. A whole facility audit conducted upon discovery of the deficient practice found no other rooms in a similar manner. C. Laminated sign will be placed by the call bell indicator as a reminder for proper placement of call bell. Education will be provided to all staff on the placement of bathroom call lights. Maintenance will add a category to their room rounding audit. (Attachment W) D. Weekly audits will occur for signage and call light positioning by maintenance and safety committee until 100% compliance is obtained for 90 days. Upon achieving the compliance and reporting compliance to QA, weekly audits can then be converted to routine monthly audits. (Attachment V)	8-14-2015

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F 463	Continued From page 26	F 463		
F 514 SS=E	<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: Based on record review it was determined that the facility failed to maintain accurate and complete clinical records for 4 (R92, R137, R157 and R97) out of 44 sampled residents. Findings include:</p> <p>1. R92's POS for May 2015 documented Novolog (insulin) sliding scale before meals and at bedtime that originated on 9/26/13.</p> <p>The May, 2015 POS also had an order to decrease the accuchecks (FSBS for sliding scale insulin) to twice a day that originated on 12/15/14.</p>	F 514	<p>A. R157's bowel and bladder assessment was found to be correct (Attachment M), R85's (clerical correction for R92 noted in survey) MAR was verified as correct upon notification of the practice (Attachment N), R137's had a correct action and result but documentation was located on back of note versus the front of the document (Attachment O); and though treatment and care was provided to R97, descriptive transition documents were missing.</p> <p>B. All residents have the potential to be affected by the practice.</p> <p>C. The staff developer/designee will educate licensed nurses on the standards of professional documentation in the medical record. The DON will review documentation daily to ensure proper documentation resident status changes and interventions are clearly reflected in the medical record. Order changes will be brought to morning meeting and the documentation will be reviewed to accuracy of events. The facility is in the process of converting to a full electronic medical record system.</p> <p>D. The DON/designee will conduct an audit of documentation daily until 100% compliance is achieved (Attachment P). Then, the DON/designee will conduct an audit 3 times per week to ensure 100% compliance has been maintained. Then, the DON/designee will conduct an audit weekly to ensure 100% compliance has been maintained. Finally, the DON/designee will conduct an audit one month later to ensure 100% compliance has been achieved. The results of the audits will be reviewed and presented to the QA committee for review and compliance.</p>	8-14-2015

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F 514	<p>Continued From page 27</p> <p>Review of the record revealed that the facility was doing the FSBS twice a day and covering with the sliding scale insulin twice a day. The 9/26/13 order was not deleted from the POS when it was changed on 12/15/14.</p> <p>2. R137's MAR for April 2015 documented (on the back of the MAR) that an as needed laxative was given on 4/1/15 with positive effect. The nurse failed to initial the administration of the medication on the front of the MAR.</p> <p>3. R157's 1/24/15 Assessment of Bowel and Bladder incorrectly documented that the resident was aware of bladder urges and was usually continent of urine. The MDS assessment dated 1/14/15 and the Admission Nursing Assessment dated 1/24/15 correctly documented the resident's urinary incontinence.</p> <p>4 A. Review of R97's nurse's note dated 3/5/15 and timed 10:48 AM stated to discontinue a specific protocol and monitoring, including daily weights. The next nurse's note, dated 3/6/15 and timed 6:49 PM (more than 24 hours later) stated there was a new order for x-rays to check for a broken femur (thigh bone, including part of hip). A nurse's note dated 3/7/15 and timed 2:18 AM stated R97 was sent to the emergency room after a fall (saw no evidence of a fall in notes) and with complaints of chest pain.</p> <p>The facility failed to have complete and accurate records; there were no nurse's note regarding the events of R97's fall that occurred on 3/6/15 (known because of incident report dated 3/6/15) which resulted in a broken hip.</p>	F 514			

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F 514	Continued From page 28 B. Review of nurse's notes from 3/5/15 to 3/23/15 revealed multiple entries stating R97 reported pain and the pain was controlled effectively by the resident's current medication regimen. The nurse's notes lacked identification of the pain site. This was especially important as R97's fall occurred on 3/6/15 and her hip was not identified as broken until 3/23/15 after R97 was sent to the hospital for a second time in March 2015. Findings were reviewed with E1 (NHA) and E2 (DON) during the informational meeting on 6/4/15 at approximately 4:40 PM. E2 confirmed findings.	F 514			



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: June 5, 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 May 26, 2015 through June 5, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 157. The survey sample totaled forty four (44).</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</p>		
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Provider's Signature

Title: Administrator of Record

Date:

7/7/2015



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>by:</p> <p>Cross refer to the CMS 2567-L survey completed June 5, 2015:</p> <p>F241, F253, F272, F279, F309, F311, F323, F371, F428, F431, F441, F463 and F514.</p>	<p>Cross refer to CMS 2567-L, received on June 22, 2015.</p> <p>Related Plan of Correction for the above addresses: F-241, F-253, F-272, F-279, F-309, F-311, F-323, F-371, F-428, F-431, F-441, F-463, and F-514.</p> <p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited.</p> <p>However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.</p> <p>This plan is submitted to meet requirements established by state and federal law.</p>	<p>8/14/2015</p>

Provider's Signature 

Title: Administrator of Record Date: 7/7/2015