

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

PRINTED: 08/08/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/01/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARBOR HEALTHCARE &amp; REHAB CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 OCEAN VIEW BLVD LEWES, DE 19958</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from June 24, 2016 through July 1, 2016. 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 155 (one hundred fifty five). The survey sample totaled 38 (thirty eight).</p> <p>Abbreviations used in this report are as follows:  NHA - Nursing Home Administrator;  DON - Director of Nursing;  ADON - Assistant Director of Nursing;  RN - Registered Nurse;  LPN - Licensed Practical Nurse;  UM - Unit Manager;  MD - Medical Doctor;  RNAC - Registered Nurse Assessment Coordinator;  CNA - Certified Nurse's Aide;  ST - Speech Therapist;  ADL - Activities of Daily Living, such as bathing and dressing;  MDS - Minimum Data Set (standardized assessment forms) used in nursing homes;  CDC - Centers for Disease Control;  Aspiration - inhaling food, fluid or vomit into the lungs;  Aspiration Pneumonia- lung infection from inhaling food, fluid or vomit;  Aspiration precautions-interventions to reduce the risk of aspiration of food/fluid;  BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15; 13-15: Cognitively intact; 08-12: Moderately impaired;</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

07/25/2016

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 00-07: Severe impairment; cc-cubic centimeter-unit of volume; Cerebral Palsy - brain disorder affecting body movement and balance; Controlled substance-a drug that is regulated by the government; Cognitive - mental process or thinking; Digoxin - medicine to help the heart beat stronger and slower; Docusate Sodium-medication that encourages bowel movements; Dysphagia - difficulty swallowing; Furosemide - medicine to eliminate excess fluid in the body; Fiber laxative-medication for constipation; Infiltrate - fluid and cells not usually present creating density within the lung; Insulin-medication that regulates the amount of sugar in the blood; mcg (Microgram) - metric unit of weight, 1,000 mcg equals 1 mg; mEq (Milliequivalent) - metric unit of weight, 10 mEq potassium equals 390 mg; mg (Milligram) - metric unit of weight, 1 mg equals 0.0035 ounce; mL (Milliliter) - metric unit of liquid volume, 5 ml equals 1 teaspoon; Narcotic-controlled substance affecting the mood or behavior; Oral suctioning-to remove secretions from the airway using a suction catheter; Pocketing - retaining food in the mouth; Puree-creamy substance; PRN- as needed; Potassium Chloride - medicine to prevent or treat low potassium levels; Pulse Oximetry (pulse ox) - measures blood oxygen levels: desired range 94% to 100%; Puree diet - food blended into consistency like	F 000			

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F 000	Continued From page 2 mashed potatoes; Rhonchi - abnormal lung sounds caused by secretions; X-ray - picture taken of bones or organs.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by : Based on direct observation, staff interviews and a review of clinical records, it was determined that the facility failed to promote and maintain a positive and dignified dining experience for three ( R48, R174, and R63) out of 38 sampled residents . R174 was not assisted for at least 30 minutes after being served a meal. R48 watched another resident being fed for 10 minutes before being served and fed and experienced minimal interaction with the CNA during the same meal. For R63, the tray and individual dishes/cups were slammed on the table when the meal was served. Findings include:  1. Surveyor observation on 6/28/16 (12:47 PM to 1:22 PM) in the Lewes Unit dining area: - R174 was seated at a table with 4 other residents and two CNAs. - R174 was served at 12:47 PM: plate (remained covered) along with a glass of milk and an individual container/serving of ice cream. - Two CNAs at the table were assisting the other	F 241	A.) (1) The facility cannot retroactively correct the lunch service provided to R63 on 6/24/16. (2) The facility cannot retroactively correct the lunch service provided to R174 on 6/28/16. (3) The facility cannot retroactively correct the breakfast service provided to R48 on 6/29/16.  B.) (1)Residents with similar dining preferences and/or who are care planned for group assisted dining have the potential to be affected. (2) The DON/designee will conduct a whole facility audit on Residents with diagnosis's and care plans requiring feeding assistance to assure care plan accuracy, location of meals, and cart and tray order to assure optimization of meal	8/31/16

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F 241	<p>Continued From page 3</p> <p>four residents with their meals.</p> <p>- At 1:20 PM, one CNA finished feeding two of the residents and assisted them out of the dining area.</p> <p>- R174 did not touch any of the meal until staff began assisting the resident around 1:21 PM, thirty four (34) minutes after being served and watching the four table mates eat.</p> <p>- At 1:22 PM, the other two residents sitting at the table with R174 were escorted out of the area because they were done with their meals.</p> <p>Interviews on 6/28/16 between 1:23 PM - 1:25 PM revealed:</p> <p>- E19 (CNA) stated they can only do (feed) two at a time so whoever is left gets done after that, there were only three staff in the dining area today.</p> <p>- E20 (CNA) thought the hospice aid was going to feed R174 but, either way, we did not have enough staff to feed everyone at one time.</p> <p>Surveyor observation at 1:35 PM that same day showed that staff were still assisting R174 with the meal and there were no other residents at the table.</p> <p>Review of R174's clinical record on 6/29/2016 and 7/1/2016 revealed the MDS completed on 3/30/16 documented the resident was severely cognitively impaired and totally dependent on staff for eating.</p> <p>Cross Refer F309, Example 2</p> <p>2. 6/29/16 (8:25 AM - 8:43 AM) - Random breakfast observation in the main dining/activity room revealed:</p> <p>- R48 watched another resident, sitting directly across the table facing R48, being fed for 10 minutes before being served and fed breakfast.</p>	F 241	<p>service time and feeding assistance. Corrections will be made accordingly.</p> <p>C.)</p> <p>(1) Education will be provided by the Staff Developer to all staff responsible for feeding assistance on the topic of Respectful Dining Procedures and Creating a Dining Experience that enhances dignity and respect.</p> <p>(2)The facility will implement a new dining observation tool derived from the QIS Survey for F241 that will be used by the Unit Managers /designee to validate proper meal assistance for Resident's care planned for assisted dining and that assistance is done timely and respectfully.</p> <p>(3) Dining observation tool will be converted into a daily checklist for meal set-up for all staff who assist with dining to assure the best environment to assure the highest level of dignity and respect for the Resident.</p> <p>D.)</p> <p>(1) Director of Nursing/designee will review ten (10) Residents potentially affected, weekly for four weeks until 100% compliance is reached for four (consecutive weeks).</p> <p>(2) Then, monitor / audit monthly until consistently reaching 100% success for three monthly evaluations. If 100% compliance is reached after the end of three evaluation periods, facility will conclude that compliance has been obtained and maintained.</p>	

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F 241	Continued From page 4 - There was minimal interaction between E22 [CNA] and R48 during the meal. Once E22 said "Here you go" and one other time the CNA patted the resident on the shoulder. No other interaction occurred during the 18 minutes feeding assistance was provided.  3. 6/24/16 - Random lunch observation in the Sussex dining/activity room discovered: - E28 [CNA] served R63 at 12:32 PM by placing the tray down hard on the table, making a slamming noise. [E28 was not smiling and appeared to be in a foul mood.] - E28 removed the plate, bowl and cups from the tray and, one by one, placed them hard on the table, making a loud noise with each item. - The CNA told R63 that she would return to take care of the drinks, but did not return. - At 12:40 PM another CNA thickened and prepared the resident's drinks after the resident began self-feeding when the meal was served.  These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM.	F 241	(3) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, it was determined that the facility failed to provide a homelike environment during dining by leaving	F 252	A.)  The facility cannot go back retroactively	8/31/16	

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F 252	<p>Continued From page 5</p> <p>served meals on trays in the Lewes Unit lounge area (area where the old nursing station was located) used as dining area. Findings include:</p> <p>During random lunch observations in the Lewes Unit lounge area revealed:</p> <ul style="list-style-type: none"> <li>- 6/27/16 (12:15 PM to 1:30 PM): 6 out of 6 residents received their meal on a tray and the dishes remained on the tray during the entire meal.</li> <li>- 6/28/16 (12:30 pm to 1:30 PM): 5 out of 5 residents received their meal on a tray and the dishes remained on the tray during the entire meal.</li> </ul> <p>During an interview on 06/30/2016 at 10:26 AM with E8 (Lewes Unit Nurse Manager), E11 (CNA), E12 (CNA) and E18 (CNA), the CNAs confirmed that leaving the dishes on the serving trays was how it had been done since they cannot put a dirty tray back in the clean food cart and another cart was not available for used trays.</p> <p>During an interview with E15 (CNA) on 2/18/16 at 12:16 PM, when asked if residents were usually served their meals on trays in the assisted dining room, E15 replied "yes always".</p> <p>During an interview with E8 on 7/1/16 at 8:15 AM these findings were reviewed and confirmed by E 8.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM.</p>	F 252	<p>and correct lunch service provided to residents eating the common area on the Lewis Wing on 6/27/16 and 6/28/16.</p> <p>B.) All Residents who may dine in the common are of Lewes memory impaired unit could be impacted.</p> <p>C.) (1) It is no longer the practice of Harbor Healthcare to allow residents to be served meals on trays while dining in the common dining area on Lewis Wing. (2) A hutch for clean linen and paper storage was delivered and installed on July 11,2016 in the common area to assist with table setting and eliminating tray service. (3) Two dining utility carts were ordered by to assist with tray, china, and flatware stacking management; one will be used for clean items that are not in-use and the second will be used to safely and sanitarly store soiled items. Estimated delivery of carts is early August 2016. (4) Lewes / Memory Care Unit staff were immediately in-serviced by the Staff Educator on adjusting table service to place trays on hutch to provide a better experience. (5) The staff educator will educate all staff on Respectful Dining Procedures and Creating a Home like Dining experience.</p> <p>D.) (1) Audit tool, referenced in F-241, will also be used to audit the dining room on</p>		

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F 252	Continued From page 6	F 252	the Lewes Memory unit to monitor residents are not being served from trays.  (2) Director of Nursing /designee will review ten meal services on Lewes Unit to assure Residents are not potentially affected by previous practice, weekly for four weeks until 100% compliance is reached for four consecutive weeks. (3) Then, monitor / audit monthly until consistently reaching 100% end of three evaluation periods, facility will conclude that compliance has been obtained and maintained. (4) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observations and interview, it was determined that for 9 (124, 126, 131, 201, 209, 214, 263, 302 and 309) out of 36 rooms reviewed, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings include:  Observations were made during Stage 1 on 06/24 /16 and 06/27/16 between 8:00 AM and 4:00 PM, 06/30/16 between 11:00 AM and 11:20 AM and	F 253	A.) 1.) The towel bars in the five (5) rooms ( Rooms 201, 209, 214, 302, and 309)were tightened on June 30, 2016. 2.) The loose sinks in the two (2) rooms ( Rooms 126 and 131) were tightened on June 30, 2016. 3.) The (2) two privacy curtains in rooms 124 and 263 were removed and replaced on June 30, 2016. 4.) The scored foot board in room 201	8/31/16	

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F 253	<p>Continued From page 7</p> <p>07/01/16 between 9:25 AM and 9:55 AM.</p> <ul style="list-style-type: none"> <li>- 5 (201, 209, 214,302 and 309) rooms with loose towel bars.</li> <li>- 2 (126 and 131) rooms with loose bathroom sinks.</li> <li>- 1 (201) room with furniture in poor repair.</li> <li>- 2 (124 and 263) rooms with soiled privacy curtains.</li> </ul> <p>Findings were confirmed in interview with E5 ( FMD), E31 (Regional Director of Operations) and E32 (Environmental Director) 07/01/16 at 10:55 AM.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM .</p>	F 253	<p>was replaced on June 30, 2016. All items were corrected before exit survey on July 1, 2016.</p> <p>B.)</p> <ol style="list-style-type: none"> <li>1.) All Residents could potentially be affected.</li> <li>2.) The maintenance director/designee will round all rooms to monitor that towel bars and sink are fastened and foot boards are in good repair. Corrections will be made accordingly.</li> <li>3.) The housekeeper director/designee will round all rooms to monitor that privacy curtains are clean. Corrections will be made accordingly.</li> </ol> <p>C.)</p> <p>The facility's preventive maintenance software program TELS has been updated to include monthly rounding on : Towel Bar integrity (not just visual inspection), sink integrity (not just functionality), and Furniture Marring / Scoring (not just visual inspection) and condition of privacy curtains.</p> <p>D.)</p> <ol style="list-style-type: none"> <li>1.) The Maintenance Director/designee will inspect all towel bars, sinks, foot boards for condition and report out to monthly QA &amp; A until a 100% compliance is achieved for three months.</li> <li>2.) The Housekeeping Director will inspect condition all privacy conditions for condition.</li> <li>3.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</li> </ol>		

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F 280 F 280 SS=D	Continued From page 8 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility 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.  This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that for one (R75) out of 38 sampled residents the facility failed to ensure the resident was invited to participate in the care planning meetings. Findings include:  Review of R75's record revealed that care planning meetings were conducted on 9/21/15, 12/17/15, 3/10/16 and 6/2/16. Review of the meeting minutes indicated that the resident's significant other attended the meetings but the resident was not listed in attendance. All the MDS	F 280 F 280	A.) Resident R75 is now being invited to her quarterly/annual care plan meetings.  B.) All residents have the potential to be impacted.  C.) 1.) Now all Residents will receive care plan notice and invitation. The paper invitation will be delivered during the mail	8/31/16

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F 280	Continued From page 9 assessments associated with these care plan meetings indicated R75 as being cognitively intact  An interview on 6/30/16 at 12:04 PM with R75 revealed that she did not attend the care planning meetings because she did not know when they were. R75 confirmed that her significant other attended but the resident often did not find out about the meeting until after it was over. R75 stated she would like to attend.  An interview on 6/30/16 at 12:15 PM with E8 (SW ) revealed that the care plan meeting invitations were being sent to the significant other because he was listed as the responsible party on the cover sheet of the clinical record. E8 further revealed that R75 was more impaired on admission 2 years ago and the responsible party information had not been updated to reflect the resident's current abilities to participate. E8 stated that she would update the record so R75 would receive the care plan invitation.  These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM.	F 280	delivery by the Activities department.  2.) The staff educator will educate activities, social services and nursing staff on the revised care plan invitation process  D.) 1.) Social Services/designee will audit weekly for four weeks until 100% compliance reached for four consecutive weeks. 2.) Then, monitor / audit monthly until consistently reaching 100% success for three monthly evaluations. If 100% compliance is reached after the end of three evaluation periods, facility will conclude that compliance has been obtained and maintained 3.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:  Based on record review, observations, interviews and review of other facility documents, it was determined that the nursing staff failed to	F 281	A.) 1.) R46 care plan was revised to include approach related to self-administration of	8/31/16

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F 281	<p>Continued From page 10</p> <p>administer medications to one (R46) of 38 sampled residents in accordance with the facility policy and acceptable nursing clinical standards of practice. Findings include:</p> <p>The facility policy titled "General Dose Preparation and Medication Administration" (last revised 1/1/13) included that during medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to, observing the resident's "consumption" of the medication(s).</p> <p>Delaware Title 24, Chapter 19- Professions and Occupations under § 1902 Definitions: a) Administration of medication...by an authorized licensed person ...assesses the patient's status to assure that the drug/medication is given as prescribed to the patient for whom it is prescribed and that there are no contraindications to the use of the drug or the dosage, gives the prescribed dose to the proper patient, records the time and dose given and assesses the patient following the administration of the medication for possible untoward side effects.</p> <p>Review of R46's clinical record revealed:</p> <p>4/12/16 Quarterly MDS documented that the resident was cognitively intact.</p> <p>5/19/16 Physicians Orders showed medication to be administered in the morning were: - Digoxin 250 mcg daily at 8:00 AM. - Furosemide 20 mg daily at 8:00 AM. - Fiber Laxative 625 mg - two tablets twice a day at 8:00 AM and 6:00 PM. - Tylenol 325 mg- two tablets twice a day at 8:00</p>	F 281	<p>medication.</p> <p>2.) Once informed by the surveyor the facility updated R46 care plan for medication self-administration and educated E9 on licensed nursing staff on the revised care plan.</p> <p>B.) 1.) All Residents with a supervised self-administration care plan could be impacted. 2.) A whole house audit was immediately completed for any Resident that was care planned for self-administration or supervised self administration of medication. Medical Director/attending reviewed all identified cases and determined appropriateness of resident to self administer. Corrections were made accordingly to Medical Director/attending recommendations.</p> <p>C.) 1.)The Staff Educator will educate Licensed Nurses on self-administrations care plans and those who have assisted self-administration; and the basics on medication administration safety. (2) Notification of self-administration or supervised administration will be added to the computer electronic medication administration record to verify proper administration method was applied.</p> <p>D.) 1.) Director of Nursing/designee review five Residents who have self-administration or supervised administration medication passes with a</p>	

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F 281	<p>Continued From page 11 AM and 6:00 PM. - Docusate Sodium 100 mg daily at 8:00 AM. - Potassium Chloride 10 mEq daily at 8:00 AM.</p> <p>6/28/16 observation (11:30 AM-11:45 AM) - R46 was in his room and 7 medications were sitting on a napkin on the resident's bed. R46 stated they were his morning medications and he would take them later.</p> <p>During an interview with E10 (LPN, Charge Nurse ) on 6/28/2016 at 11:48 AM E10 was shown the medications on the resident's bed and stated that it is the resident's preference because R46 does not like to be rushed. E10 further stated that R46 does not like for the nurse to stand in the room so generally the nurse stays out by the cart. The surveyor noted that there was no medication cart or nurse available in the hallway area. E10 indicated that E9 (LPN) gave R46's morning medications.</p> <p>During an interview with E9 on 6/29/16 around 11 :49 AM E9 stated that R46 took the Digoxin but the other medications were left on a napkin on the bed for the resident to take later. E9 indicated that R46 takes the medications, the resident can only take one at a time and does not like to be watched or rushed. The resident did take the medications after the interview with E9.</p> <p>The 7 medications left on the bed were identified as Tylenol (2), Potassium Chloride (1), Fiber Laxative (2), Docusate Sodium (1), and Furosemide (1).</p> <p>June 2016 eMAR - E9 documented on 6/28/16 at 7:55 AM that the resident requested all of the</p>	F 281	<p>success audit tool, weekly for four weeks until 100% compliance is reached for four consecutive weeks.</p> <p>2.) Then, monitor / audit monthly until consistently reaching 100% success for three monthly evaluations. If 100% compliance is reached after the end of three evaluation periods, facility will conclude that compliance has been obtained and maintained.</p> <p>3.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

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F 281	Continued From page 12 pills at once and she signed that they were given; yet, the resident did not take 7 of the 8 pills until at least 11:49 AM.  6/29/16 review of R46's current care plan revealed: - There was an identified problem for Cognitive Loss- chronic/progressive decline in intellectual functioning characterized by a deficit in memory, judgement and decision making (initiated 5/6/15). - Nursing added an approach to the problem area of Cerebral Palsy on 6/29/2016 at 11:32 AM that resident preferred medications to be placed on a napkin to assist R46 in placing them in mouth and at own pace. This approach was added a day after the surveyor observed the medications left on a napkin on the resident's bed. - There was no identified area or approach related to self-administration of medication	F 281			
F 309 SS=D	The findings were reviewed with E1 (NHA) and E 2 (DON) on 7/1/2016 at 3:15 PM. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by : Based on observations, record review and interview it was determined that the facility failed	F 309	A.) 1.) The facility cannot retroactively correct	8/31/16	

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F 309	<p>Continued From page 13</p> <p>to follow the comprehensive plan of care for three (R98, R48 and R35) out of 38 sampled residents by not following swallowing precautions guidelines during meals. Findings include:</p> <p>1. Review of R98's care plan found the following problems related to swallowing issues (dysphagia):</p> <ul style="list-style-type: none"> <li>- Resident aspirated and is at risk for aspiration pneumonia (originally written 2/3/16, last reviewed 5/11/16) included interventions to: Provide resident with encouragement to eat small bites and alternate liquids and solids; Refer to speech therapy as needed for changes in status including choking, coughing or any other signs and symptoms of aspiration.</li> <li>- Potential for aspiration or decreased oral intake due to diagnosis of dysphagia (originally written 2/11/16, last reviewed 5/11/16) included interventions to: Puree diet with nectar thick liquids, no pork; May have ice cream; Feeding assistance: dependent [must be fed by staff]; Swallowing precautions and strategies listed: No straws. Small bites/small sips; Liquids and solids by 1/2 teaspoon; Alternate solids and liquids.</li> </ul> <p>4/16/16 - R98's Functional Mobility/Transfer Status paper in the CNA documentation binder listed swallowing precautions and strategies to include small bites. Other interventions recorded were small 1/2 teaspoon presentation and check for pocketing.</p> <p>R98 was observed being fed by staff during three random meals: 6/24/16 - Lunch observation in the Sussex unit's dining/activity room discovered: - 12:40 PM served 3 pureed items on a plate and a thickened drink.</p>	F 309	<p>meals service provided to R98 during the course of the survey</p> <p>2.) The facility cannot retroactively correct breakfast service provided to R48 on 6/29/16.</p> <p>3.) The facility cannot retroactively correct lunch service provided to R35 on 6/29/16.</p> <p>4.) Once the facility was informed by the surveyor E22 and E23 was educated on R35,R98,R48's dysphasia care plans.</p> <p>B.)</p> <p>1.) All Residents with similar dysphasia care plans could be affected.</p> <p>2.) A whole facility audit will be conducted on Residents with similar diagnosis's, care-plans for assisted dining, and speech therapy care plans that require any recommendations. All identified Residents will have care plans reviewed and verified for assisted dining care plans, with reviews by speech therapy. Correction and staff education will done accordingly.</p> <p>C.)</p> <p>1.) Shallow bowled, long-handled Demitasse Spoons were purchased for adaptive use of all who require "small bites" and "slowing down" techniques recommended by the speech therapist</p> <p>2.) The Staff Developer will educate licensed nurses and certified aides on the use of the defined adaptive equipment.</p> <p>3.) In order for staff to easily access the Speech Therapist recommendations they will be highlighted in flow books that located on all units and recommended techniques will be also added to meal</p>	

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F 309	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- E22 (CNA) fed large, heaping spoonfuls of food in a repetitive and hurried fashion while intermittently offering drink from a cup. Food covered the entire surface of the spoon and ranged from 1/2 to 1.5 inches in height on the spoon.</li> <li>- The 3 pureed items on the plate and the drink were finished at 12:47 PM, seven minutes after starting.</li> </ul> <p>6/27/16 - Lunch observation in the main dining/activity room discovered:</p> <ul style="list-style-type: none"> <li>- 12:20 PM served pureed meal of roast beef, peas, mashed potatoes and a thickened drink.</li> <li>- E23 (CNA) fed the resident: each spoonful of food covered the surface of the spoon and appeared around 1/2 - 1 inch in height on the spoon.</li> <li>- Several times during the meal, R98 closed her mouth. E23 provided verbal encouragement and pushed the spoon with food between the resident's lips and R98 resumed eating.</li> <li>- R98 fell asleep part way through the lunch and did not finish the meal.</li> </ul> <p>6/29/16 - Breakfast observation in the main dining/activity room discovered:</p> <ul style="list-style-type: none"> <li>- 8:34 AM served the meal with eggs and two other pureed items on a plate.</li> <li>- E22 began feeding R98 with heaping spoonfuls of food, then switched over to smaller amounts of food including both full and half teaspoons.</li> <li>- Several times during the meal R98 closed her mouth so E22 provided verbal encouragement and pushed the spoon with food between the resident's lips to get R98 to resume eating.</li> <li>- R98 finished eating the entire meal at 8:48 AM.</li> </ul> <p>R98 was fed at all three observed meals with</p>	F 309	<p>tickets.</p> <p>4.) An audit tool will be developed to monitor the use of the adaptive equipment and the implementation of the Speech Therapist recommendations.</p> <p>D.)</p> <p>1.) Director of Nursing/designee will review ten Residents charts for implementation of adaptive equipment and Speech Therapist recommendations for four weeks until 100% compliance is reached for four consecutive weeks.</p> <p>3.) Then, monitor / audit monthly until consistently reaching 100% success for three monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained.</p> <p>4.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>	

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F 309	<p>Continued From page 15</p> <p>larger quantities than the care planned 1/2 teaspoon.</p> <p>2. R48's care plan problem for Potential for Aspiration due to the diagnosis of dysphagia ( originally written 2/11/16, last reviewed 8/3/16) included the following interventions: Puree diet; Dependent for feeding; Honey consistency for liquids. Specific swallowing precautions and strategies included small bites and small sips.</p> <p>6/29/26 - Breakfast observation in the main dining /activity room discovered: - 8:25 AM served puree meal with eggs, french toast/syrup, sausage, a bowl of hot (grits) cereal, two cups of thickened milk and a cup of thickened orange juice using a teaspoon. - E22 (CNA) fed R48 with each spoonful of food covering the surface of the spoon and appeared around 1/2 - 1 inch in height on the spoon. Liquids were presented on a spoon in smaller quantity (1/2 to 1 teaspoon). - On 12 occasions during the meal E22 had a spoon holding food or juice at the resident's lips before the resident swallowed what was already in the mouth. The CNA was attempting to feed at a faster pace than the resident was swallowing. - R48 coughed at least 6 times during the meal. - The resident was fed all food items, the orange juice and one cup of milk: the meal ended at 8:43 AM with grits and milk.</p> <p>6/29/16 (9:26 AM) - R48, sitting in a wheelchair at the Sussex unit's nursing station, observed to have thick white liquid [looked like milk and grits] coming out of the right side of the mouth running down to her chin. E29 (CNA) wiped R48's mouth and placed a washcloth on the resident's chest after asking R48 if she was okay. At 9:36 AM R</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>48 was observed to have more thick white liquid was coming out of her mouth and running down her chin.</p> <p>R48 was fed heaping spoonfuls of food during this meal lasting 18 minutes at a faster pace than the resident was swallowing and ended up with some items seen coming out of her mouth, 43 minutes after meal completion.</p> <p>3. R35's care plan problem for Potential for aspiration or decreased oral intake due to diagnosis of dysphagia (originally written 4/1/8/16, last revised 6/2/16) included the following interventions: Aspiration precautions; Out of bed for meals: Oral suctioning PRN; Puree diet; Dependent for feeding; Nectar thick liquids: Stop feeding if observed holding or spitting food. Swallowing precautions and strategies documented small bites/small sips and to alternate solids and liquids.</p> <p>6/2/16 (3:06 AM) nursing note - At the beginning of the shift resident noted to have increase in oral secretions, not clearing them. Resident suctioned orally for a moderate amount of white secretions. Lungs with rhonchi, no fever, pulse ox 95% no respiratory distress noted. Continued to have several episodes of needing to be suctioned. At 10:45 PM resident vomited large amount of at least 500 ml (over two cups) of liquid with slight pink tint, but not too bloody, possible cranberry juice. . . Did update MD when calling about another resident and will see R35 in the morning.</p> <p>6/2/16 (5:30 PM) - Physician orders included an antibiotic for 7 days for slight upper lobe infiltrate shown on a chest x-ray taken earlier in the day.</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>6/3/16 (4:24 PM) nursing note - Speech therapy evaluation completed and recommended puree diet with nectar thick liquids. Head of bed to be at 45 degrees and medications to be crushed and given in applesauce or pudding.</p> <p>6/29/16 - Lunch observation in the large dining/ activity room discovered:</p> <ul style="list-style-type: none"> <li>- 12:35 PM R35 was served pureed meal of roast beef, green beans, mashed potatoes, cake, ice cream and thickened milk.</li> <li>- E22 (CNA) placed a heaping spoonful of mashed potato in the resident's mouth as the resident made a laughing sound. The resident held her mouth open and did not swallow the food</li> <li>- The CNA attempted to put another spoonful of food in the resident's mouth even though the first spoonful had not been swallowed. R28 spit out the mashed potatoes.</li> <li>- E22 gave R35 a spoonful of peas which the resident promptly spit out.</li> <li>- After the CNA changed over to milk, ice cream and cake, the resident ate and finished those items.</li> <li>- On several occasions E22 had a spoon with cake, ice cream or milk at the resident's lips before the resident swallowed what was already in the mouth. The CNA was attempting to feed R 35 at a faster pace than the resident was swallowing.</li> </ul> <p>During an interview with E24 (RN, UM) on 6/30/ 16 at 8:15 AM the surveyor described the aforementioned dining observations. E24 stated the only resident that would need large spoonfuls and fast feeding would be R98, indicating the reason was that the resident should have</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>constant intake of food to keep her mouth open. Once R98 realizes there is food and she opens her mouth, "we need to keep the food coming or she will clamp down" (close her mouth). When asked if the feeding technique was included in her care plan, E24 said was not sure and said that "it could be added if needed", but was not sure how to word it. [This technique contradicts the swallowing precaution guidelines recommended by ST.]</p> <p>An interview with E30 (ST) on 6/30/16 at 1:40 PM discussing the dining observations of R98, R48, and R35 revealed:</p> <ul style="list-style-type: none"> <li>- E30 stated "I'm not surprised" and added the "staffing ratio for the aides makes it difficult to follow the swallowing recommendations" (small bites and sips, slowing down to assure food swallowed before next spoonful is given).</li> <li>- The facility "used to have a restorative dining aide to help make sure swallowing precautions were being followed during meals, but not any more".</li> <li>- Nursing had asked ST in the past to change the swallowing precautions but E30 was resistant trying to do what was best for the resident.</li> <li>- E30 stated that swallowing precautions for R98, R48 and R35 are as lenient as can be. The recommended "1/2 teaspoon for R98 was based on the swallow study performed within the past year".</li> </ul> <p>During an interview with E25 (Staff Development/ Infection Control Practitioner) on 7/1/16 at 8:30 AM E25 stated she "went around to all the aides yesterday afternoon and reinforced the need to follow swallowing precautions" telling them "I know you want to get done fast, but it is best for the resident."</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARBOR HEALTHCARE &amp; REHAB CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 OCEAN VIEW BLVD LEWES, DE 19958</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 19	F 309			
F 431 SS=D	<p>These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM.</p> <p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/ STORE DRUGS &amp; BIOLOGICALS</b></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>	F 431		8/31/16	

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F 431	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, record review, staff interview and review of other facility documents, it was determined that the facility failed to ensure that expired medications were removed from 1 out of 5 medication carts. In addition, the nursing staff failed to complete narcotic counts based on acceptable standards of practice and in accordance with facility policy on 3 of 3 units.</p> <p>Findings include:</p> <p>Manufacturer guidelines for insulin states that an open bottle of insulin at room temperature is only good for 28 days (4 weeks) then should be discarded.</p> <p>1. 7/1/2016 (11:00 AM) observation of the Sussex Unit Front Hall medication cart found: - 1 expired insulin bottle being used for sliding scale insulin four times a day with the open date written on label as 5/28/16 (expired 6/25/16). - 1 insulin bottle being used without an open date written on label; however, the bottle was dispensed to the facility within the past 28 days.</p> <p>On 7/1/16 at 11:30 AM these findings were reviewed and confirmed with E16 (LPN) and E17 RN (Unit Manager).</p> <p>2. 7/1/16 (12:00 PM) observation of the Henlopen Wing narcotic count book found E15 ( LPN) and E34 (LPN) signed on the line for 7 AM change of shift narcotic verification record sheet but did not write the amount of medication for 5 of 6 areas to be counted nor the date or time of the</p>	F 431	<p>A.) No Residents were impacted.</p> <p>B.) 1.) All Residents have the potential to be impacted. 2.) Whole house audit was immediately completed to assure any expired medications were discarded and labeling was update as needed. 3.) Whole house audit completed to assure the narcotic count is completed accurately.</p> <p>C.) 1.) Now Unit Managers and Nursing Supervisors will required to audit carts weekly and to properly dispose of expired medication and labeling of open date on the insulin bottles 2.) Pharmacist will also conduct random medication carts audits during each monthly facility visit to monitored for expired medications and open dates on insulin bottles. 3.) Unit Managers/ supervisors/designee will check narcotic sheets at the beginning of their shift to monitor that the facility policy is being followed; two nurses signed, the number of medication is documented along with the date and time of the count. 4.)The Staff Educator will educate the license nurses and pharmacist on the new procedures to audit medication carts for</p>		

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F 431	Continued From page 21 count.  This finding was immediately reviewed and confirmed with E15 [LPN] who stated she was working a double shift from 7 AM - 11 PM today and intended to fill in these counts before leaving the facility today.  3. On 7/1/2016 between 11:00 AM and 1:00 PM, surveyors reviewed narcotic verification/count record books from 5 separate medication carts covering 5/23/16 - 7/1/16 and found 10 separate days involving 4 of the 5 narcotic verification/count books were missing at least one signature from the oncoming and/or the off going nurse.  The facility's policy Appendix 15 - Shift Verification Substances documented that: 1. Two licensed nurses shall reconcile all doses of controlled substances stored in the assigned medication cart at the change of shift. 2. The oncoming nurse shall inspect each package of controlled medication and read the remaining quantity in each package. 3. The off-going nurse shall read the remaining quantity documented on each resident Controlled Substance Declining Inventory Record and record their findings. (Example: Reconciled). 4. Each nurse performing the reconciliation shall place his/her signature on the appropriate line for the date and shift.  These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM.	F 431	expired medications, correct labeling of. 5.) The Staff Educator will re-service licensed nurses on the facility's Shift Verification Substances policy,  D.) 1.) Staff Developer/designee will conduct weekly audits on all medication carts, and narcotic sheets four weeks until consistently reaching 100% success for to monitor that expired medications have been discarded, insulin bottles marked with open date , and narcotic sheets are completed properly. 2.) If 100% compliance is reached after the end of four evaluation periods, facility will complete monthly to achieve 100% compliance. 3.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an	F 441		8/31/16	

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F 441	<p>Continued From page 22</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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 record review, review of facility policies</p>	F 441	A.)		

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F 441	<p>Continued From page 23</p> <p>and interview it was determined that the facility failed to obtain the results of tuberculosis (TB) skin tests for three (R213, R230 and R231) out of 5 sampled residents. Findings include:</p> <p>1. Facility policy entitled Screening Residents for Tuberculosis (last revised July 2013) included that a resident newly admitted or readmitted without a documented negative tuberculosis skin test within the previous 12 months will receive a baseline (two-step) tuberculosis skin test upon admission. If the first tuberculosis skin test is negative, a follow-up skin test will be administered 1 to 3 weeks after the initial test is read.</p> <p>A. Review of R213's clinical record revealed: June, 2016 MAR documented 5/25/16 tuberculosis (TB) skin test #1 with result as negative.</p> <p>May, 2016 eMAR documented 5/31/16 TB skin test #2 administration, but no result was recorded</p> <p>There was no evidence of the TB skin test result in the nursing notes or the Preventative Health Care section of the EMR.</p> <p>During an interview 6/27/16 at 2:30 PM with E26 ( RN) when asked where the results of TB tests were recorded, the nurse opened R213's Preventative Health Care section of the EMR and upon discovering the result query was blank, said "It's not there." After finding no results on the resident's paper MAR, E26 stated she would check the notes.</p> <p>B. Review of R230's clinical record revealed:</p>	F 441	<p>The Tuberculin steps were found on paper copy with results on June 30, 2016, for Residents R213 and 230. Resident 231 had a step 2 completed in other long term care setting but was result was not listed. Discharging facility verified step revised test pending.</p> <p>B.)</p> <p>1.) All Residents could be impacted. 2.) A whole facility audit was immediately conducted to verify that all residents requiring a Tuberculin test had both test completed both steps are documented in the EMAR. Corrections were made accordingly.</p> <p>C.)</p> <p>1.) The Staff Educator will educate Licensed Nurses on process of entering the two step process in the eMAR and how to monitor that both test were completed and entered into the Electronic Medical Record system timely. 2.) The DON/designee will now generate a report from the medical record software showing all vaccinations administrator including the TB test. That report will be reviewed in morning meeting for compliance.</p> <p>D.)</p> <p>1.) The DON/designee will audit the timeliness of TB testing and documenting the results of the tests in the eMAR. She will review all residents vaccinations administration and documentation for four consecutive weeks, until reaching 100% compliance.</p>	

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F 441	<p>Continued From page 24</p> <p>June, 2016 eMAR documented 6/16/16 TB skin test #1 administration. Reading the result was signed off by the nurse, however no result was found on the eMAR, corresponding nursing notes or the Preventative Health Care section of the EMR.</p> <p>June, 2016 eMAR documented 6/23/16 TB test # 2 with a negative result.</p> <p>During an interview with E25 (Infection Control Practitioner/Staff Development) on 6/29/16 at 2:30 PM E25 stated R230's order was entered in computer without the drop down box to type in the result. E25 confirmed that the first TB test was signed off in eMAR that it was read, but no result was on the eMAR or in the nursing notes.</p> <p>C. Review of R231's clinical record revealed: The resident was admitted 6/9/16 from another long term care facility.</p> <p>Review of the Preventative Health Care section of the EMR and nursing notes found no evidence that the resident received the TB skin tests upon admission.</p> <p>Review of R231's records from the prior facility found no results from the 2/20/16 and 3/4/16 TB skin tests performed there.</p> <p>During an interview with E25 on 6/29/16 at 2:30 PM E25 stated that R231's TB skin test results should be in paperwork from the other facility and that the dates should be added to electronic record.</p> <p>During an interview with E24 (RN, UM) on 6/30/16 at 8:15 AM when reviewing the missing TB</p>	F 441	<p>2.) Then, monitor / audit for four months until consistently reaching 100% success for three monthly evaluations. If 100% compliance is reached after the end of three (evaluation periods, facility will conclude that compliance has been obtained and maintained.</p> <p>3.) Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

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F 441	Continued From page 25 skin test results, E24 stated she would contact the previous facility for the results.  6/30/16 fax of the Immunization / Vaccination Record from the previous facility - TB skin test results were negative on 2/23/16 and 3/7/16.  These findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/16 at 3:15 PM .	F 441			



**DELAWARE HEALTH  
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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 Healthcare and Rehabilitation Center

**SURVEY COMPLETED:** July 1, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p>An unannounced annual survey was conducted at this facility from June 24, 2016 through July 1, 2016. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was one hundred fifty five (155). The stage 2 survey sample was thirty eight (38).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed July 1, 2016: F241, F252, F253, F280, F281, F309, F431 and F441.</p>		

Provider's Signature  Title Nursing Home Administrator Date July 25, 2016



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**STATE SURVEY REPORT**

NAME OF FACILITY: Harbor Healthcare and Rehabilitation Center

SURVEY COMPLETED: July 1, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201.5.6</p> <p>3201.5.6.1</p>	<p><b>Dementia Training</b></p> <p><b>Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.</b></p> <p><b>This requirement is not met as evidenced by:</b> Based on interview and review of other facility documentation it was determined that the facility failed to ensure 1 (E33, LPN) out of 5 sampled nurses received dementia specific training within the past year. Findings include:</p> <p>On 6/29/16 at 3:00 PM, the surveyor provided E25 (Staff Development / Infection Control Practitioner) with a written list of 5 randomly selected nurses (2 RNs and 3 LPNs) to show when their latest dementia training was completed.</p> <p>On 6/30/16 at 8:30 AM E25 displayed the courses completed for each of the requested nurses on the computer in E25's office. The education software showed courses within the past year and not from any previous time frame. When opening E33's listing, E25 stated "I think she's on my list." E25 confirmed that E33 had not completed any dementia training in the previous year.</p> <p>On 6/30/16 around 12:30 PM E25 informed the survey team that E33 completed the</p>	<p>A.) No Residents were impacted.</p> <p>B.) (1) All Residents that have a diagnosis of Dementia could be impacted. (2) Staff Educator/designee will perform a whole house compliance audit for curriculum on memory care training, and require staff for compliance to training. Staff will be trained as required.</p> <p>C.) Harbor Healthcare uses an electronic education program to assist with orientation and continuing education. Though an employee may complete the program for training, if the exit survey and questionnaire is not complete, the system will show that the training is not complete, even though the education / class has been completed. An audit tool will be introduced to review the compliance of the Relias education for compliance in Delaware mandatory training (excluding Elsevier requirements), but also facility initiative training.</p> <p>D.) (1) Staff Development Director/designee will perform an audit on required training on fifteen different employees weekly, four weeks until 100% compliance is reached for four consecutive weeks. (2) Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>	<p>August 31,2016</p>

Provider's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_



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**STATE SURVEY REPORT**

**NAME OF FACILITY:** Harbor Healthcare and Rehabilitation Center

**SURVEY COMPLETED:** July 1, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>dementia training that morning after the inquiry by the surveyor reviewing the dementia training.</p> <p>This finding was reviewed with E1 (NHA) and E2 (DON) on 6/30/16 at 3:15 PM.</p>		

Provider's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_