

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

PRINTED: 05/20/2016
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 C 05/06/2016
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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 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility from May 3 to May 6, 2016. The deficiencies cited in this report are based on record reviews, staff interviews, and review of other facility documentation as indicated. The sample size included four (4) active and three (3) closed records. Census 159.</p> <p>Abbreviations and definitions used in this report are as follows: -DON - Director of Nursing; -ADON - Assistant Director of Nursing; -NHA- Nursing Home Administrator; -CNA- Certified Nurse's Aide; -LPN- Licensed Practical Nurse; -RN- Registered Nurse; -UM- Unit Manager; -SSA - Social Services Assistant; -RNAC- RN Assessment Coordinator, the nurse primarily assigned to assess residents and initiate care plans; -ST - Speech Therapist, a professional who provides treatment for swallowing and communication disorders MOS- Minimum Data Set - standardized assessment tool used in long term care facilities; BIMS- Brief Interview for Mental Status; Cognitively Impaired- abnormal mental process, thinking or mental decline, losing the ability to understand and reason; MAR- Medication Administration Record; Incontinence-the inability to control the bowel and bladder; Dementia- a severe state of cognitive impairment that can interfere with a person's ability to function; Delirium- is sudden severe confusion due to rapid</p>	F 000	<p>This plan of correction received on May 20, 2016, 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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Nursing Home Administrator	(X6) DATE May 27, 2016
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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 changes in brain function that occur with physical or mental illness; Wanderguard- an alarm system, usually an ankle or wrist type bracelet, that responds and alarms to sensors placed around doors or areas that are not to be accessed freely; Ativan - antianxiety (nervousness) medication; Bolus infusion- a relatively large volume of fluid (saline) injected/infused into the body; Hypothermia- potentially dangerous drop in body temperature , usually caused by prolonged exposure to the cold temperatures and the core temperature drops below 95; incontinence- the inability to control the bowel and/or the bladder; eloped-run away.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of other facility documentation as indicated, it was determined that for one (1) of seven (7) residents reviewed (R3), the facility failed to demonstrate prompt efforts to resolve a reported grievance related to a lack of timely incontinence care. Documentation indicated that there was a delay in corrective action and a repeat grievance was then made. During the time (2 days) the facility was investigating the original grievance, there was no evidence that	F 166	A- R3 was discharged from facility on 5/4/2016 to home. Investigation to concern was started upon receipt. Frequency of rounding and monitoring increased, but duration was not determined or shared with family.R3's care plan ultimately adjusted to every two (2) hour checks, and only one hour in wheelchair, twice a day maximum. Resident's planned discharged home occurred before next review. Family verified during, and un-scheduled, in-person interview that concerns were alleviated by consistently increased schedule on April 26, 2016 B- As that all Residents could potentially be affected, a focused audit will be conducted by Social Services Director, Director of Nursing, and Nursing Home Administrator on all current active and recently resolved grievances for the past thirty (30) days to determine if there were any other occurrences, wherein an immediate care concern was processed under a grievance instead of an immediate investigation. If occurrences discovered, immediate care actions will be put in place if any are discovered.	6-30-2016

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F 166	<p>Continued From page 2</p> <p>timely actions were implemented to ensure that R3, an incontinent resident, was receiving the care he needed and that the grievance was resolved. Findings include:</p> <p>MDS documentation dated 4/21/16 indicated that R3 was incontinent of bowel and bladder and was totally dependent on staff for transfers and bed mobility.</p> <p>According to a facility grievance / concern form dated 4/20/16, E15 (spouse of R3) reported to E7 (SSA) that she felt R3 was receiving inadequate care and that she (E15) did not want R3 left sitting for any length of time after he had been incontinent. According to this form, two days later on 4/22/16, E6 (UM, Henlopen unit) instructed the nursing staff to make more frequent rounds to check on R3 and to limit his time up in the wheelchair. In an interview with the surveyor on 5/4/16 at 11:40 AM, E6 explained that she wrote down the instruction for more frequent rounding on a communication board in the staff lounge but that she did not specify a frequency and did not write the instruction in R3's clinical record. E6 stated that she was aware of E15's concerns, had discussed them with E15, and had initiated corrective actions on 4/22/16 (increased frequency of staff rounds and limited time for R3 to be in the wheelchair).</p> <p>According to a documented call to an internal facility reporting line dated 4/24/16, E15 reported infrequent checks of R3 during her daily visits and a lack of timely incontinence care. The documented response according to a grievance / concern form dated 4/24/16 was to increase visits to R3 and his family.</p>	F 166	<p>C- To eliminate future occurrences, grievances will continue be reviewed at morning meeting to determine timely follow-up and resolution to concern, as well as part of monthly and quarterly Quality Assurance meetings. Additionally: 1.) Grievance form will be amended to include an "Intermediate / Immediate Action" section (Attachment 1). 2.) Staff Developer / Designee will educate all staff on changes to grievance form and how to follow the "Intermediate / Immediate" section of the form, where applicable. 3.) Staff Educator / Designee will educate nursing staff on utilization of flow records to document follow-up of interventions and evaluations pertaining to the form.</p> <p>D- Administrator / Director of Nursing / Designee will monitor all grievance/concerns daily until facility consistently reaches 100% compliance over four (4) weekly consecutive evaluations (Attachment 2). Then, monitor all grievances 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>	

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F 166	Continued From page 3 There was a lack of evidence of timely efforts initiated after E15's 4/20/16 grievance was filed with the facility. Some efforts were communicated to staff on 4/22/16, however, there was no documentation of the actual implementation of these efforts or evaluation of their effectiveness. A second grievance was reported by E15 on 4/24/16 related to the same care concerns she had reported on 4/20/16. These findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 5/6/16 at 2:20 PM.	F 166	A- R3 was discharged from facility on 5/4/2016 to home. Resident was discharged prior to completing a secondary, corrective, mental health assessment based on clarification of communication assessment.	6-30-2016
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; Dental and nutritional status; Skin conditions;	F 272	B- As that all Residents with communication impairment could potentially be affected, a focused audit will be conducted on all current Resident Minimum Data Sets (MDS's) that have an active aphasic diagnosis' and monitor plans of care so that they accurately reflect communication needs. Any Resident discovered with a aphasic diagnosis or similar condition will have their communication and mental health assessments verified for accuracy and consistency. Any assessments that are found to be inconsistent will be corrected with a new collaborative and clarification assessment.	

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F 272	<p>Continued From page 4</p> <p>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:</p> <p>Based on record review and staff interview, it was determined that for one (1) of seven (7) residents reviewed (R3), the facility failed to complete an accurate assessment of mental status. R3 was unable to speak due to a stroke but had the ability to understand and answer questions. The section of the MDS which is used to evaluate mental status was not completed although R3 was an alert and oriented resident who was able to communicate without speech. Findings include:</p> <p>The MDS dated 4/21/16 contained documentation that R3 was rarely understood and the mental status assessment (involving questions asked of a resident to evaluate orientation and awareness) would be skipped (omitted). State agency investigator interview with E16 (SW) on 5/4/16 at approximately noon revealed that she did not perform the mental status assessment because R3 could not speak and that E16 lacked</p>	F 272	<p>C- Staff Educator / Designee will educate Social Work staff on coding and interview techniques of the c0100 - c1000 codes of the Minimum Data Set (MDS). Additionally, all residents with an aphasic diagnosis will receive a request for a Speech Therapy evaluation on admission care plans and with significant changes to care plan to assure the appropriate communication techniques are used.</p> <p>D- Registered Nurse Assessment Coordinator (RNAC)/designee will monitor / audit (Attachment 3) eight (8) Residents weekly for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. 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>	

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F 279	<p>Continued From page 6</p> <p>seven (7) residents reviewed (R 1) the care plan developed by the facility failed to include a clear instruction for daily weight monitoring of R1 as ordered by the physician for medical reasons (heart disease in which excess fluid can build up in the body). Findings include:</p> <p>R1 had a care plan addressing her potential for complications related to heart disease in which excess fluid can build up in the body. Approaches included monitoring R1 for weight gain and weighing R1 according to a facility protocol specific to R1's heart disease. When the surveyor asked for a copy of the protocol, E4 (RNAC) looked for it and then told the surveyor on 5/6/16 at 12:15 PM that the protocol was no longer in use since a recent change in management companies had resulted in the implementation of different policies / procedures. In addition to the care plan instruction to monitor R1's weight, the physician ordered daily weight monitoring at the time of admission (11/19/15). The physician wrote the order again on 11/20/15 instructing staff to weigh R1 daily. R1's weight was recorded for 11/20/15 and 11/21/15 but no weights were recorded for 11/22, 11/23, or 11/24/15 (date of R1's discharge from the facility).</p> <p>These findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 5/6/16 at 2:20 PM.</p>	F 279	<p>D- Staff Educator/designee will monitor / audit (Attachment 4) all Residents on daily weights through reports within Electronic Medical Record (E-MAR) weekly until consistently reaching 100% compliance over four (4) weekly consecutive evaluations. 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>	
F 312 SS=D	<p>483.25(a)(3) AOL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312	<p>A- R3 was discharged from facility on 5/4/2016 to home. Prior to Admission, R3 preferred showers at home when able to transfer from bed to shower. Post admission, R3 was unable to transfer and preferred bed or sponge baths to showers, despite being a prior preference. Staff used shower log to document refusal, but did not document that bed bath occurred instead. Interview with family verified that bed baths occurred at least twice a week, if not more.</p>	6-30-2016

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F 312	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that for one (1) of seven (7) residents reviewed (R3), the facility failed to provide the necessary services to maintain good hygiene. There was a lack of evidence that R3 was offered and received his preferred method of bathing (bed baths). Findings include:</p> <p>R3 had a physician order for showers twice a week . Social Services assessment dated 4/14/16 and MDS documentation dated 4/21/16, however, indicated that R3 strongly preferred bed baths or sponge baths instead of showers. Bathing documentation revealed that R3 refused showers three times in April, 2016 (4/15, 4/19, and 4/22/16) with blank spaces or illegible documentation for 4/26 , 4/29 , 4/30 and 5/3/16. R3 was discharged from the facility on 5/4/16 . There was a lack of evidence that R3 was offered and received sponge baths during his 3 week stay in the facility .</p> <p>These findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 5/6/16 at 2:20 PM.</p>	F 312	<p>B- As that all Residents could potentially be affected, a focused audit will be conducted by the Director of Nursing, Social Services, and all Unit Managers on all current Resident's charts to determine that bathing preferences, abilities, and care planned variations are consistent between flow books, care plans, orders, and Minimum Data Set (MDS). Any inconsistencies will be immediately reviewed and corrected with clarification with Resident / Family and facility care team. Audit will include when there is documentation of shower refusals, that alternatives were offered or provided and documented accordingly.</p> <p>C- To assure compliance: 1.) Director of Nursing/designee will educate all licensed staff on flow sheets, orders and care plans reflecting resident preferences, if necessary. 2.) Social Services will communicate preferences at morning meeting if Social Services assessment indicates a specific resident preference. 3.) Staff Educator/designee will educate Social Services department on the timely informing appropriate disciplines regarding changes in Resident preferences on bathing identified during Social Services assessment at morning meeting. 4.) Perform a Utilization of Daily shower audit for Certified Nursing Aide's (C.N.A.'s) to complete each shift to document showers, shower refusals(if occurred), verification of alternative, flow book completion, and nurse notification.</p>	
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, a review of a clinical record and relevant facility documents, it was determined that the facility failed to provide adequate staff supervision, ensure that all doors in the secured Lewes Unit were alarmed, and/or that the magnetic door lock system on the Unit had a back-up system/plan in the event of a power failure. One (R2) of 7 sampled residents who had made attempts to leave the Unit; eloped on 10/2/15 from the secure unit, was found outside (Temperature 56 F) in the rain, taken to the emergency room, admitted for treatment of hypothermia and discharged 3 days later. This deficiency is past noncompliance and was corrected on 10/5/15. Findings include:</p> <p>R3's clinical record indicated the following: 8/7/15 at 20:00 [8 PM] - MAR showed that R2 received an as needed medication - Ativan 1 mg. for "exit seeking and restless" behaviors. 8/13/15 at 19:55 [7:55 PM] - nursing- Resident seen by nurse and other staff, getting up from chair and running toward exit doors. Staff attempted to catch resident, but were unable to stop his/her before he/she exited doors. Resident followed and redirected by 2 staff with positive effect. No further attempts noted. Wanderguard placed on left ankle. 8/13/15 at 21:04 [9:04 PM] - nursing - New orders for wanderguard at all times; check placement every shift. 8/13/15 - Observation Reports- Quarterly Assessment - Risk of ElopemenUWandering</p>	F 323	<p>D- Director of Nursing/designee audit / monitor (Attachments 5 and 6) a sample of twenty percent (20%) of Resident charts, focusing on refusals, daily until consistently reaching 100% compliance over five (5) daily consecutive evaluations. Then monitor / audit twenty percent (20%) of Resident charts weekly until consistently reaching 100% compliance for three (3) evaluations, then monitor twenty percent (20%) monthly until consistently reaching 100% compliance over 3 consecutive 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>Past noncompliance: no plan of correction required.</p>	

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F 323	<p>Continued From page 9</p> <p>Review document completed by nursing indicated the following [These are yes or no answers with some comments]:</p> <p>Is the resident cognitively impaired with poor decision-making skills? - "yes."</p> <p>Has the resident expressed a desire to go home, packed belongings to go home or stayed near exit? - "yes."</p> <p>Is the wandering behavior a pattern, goal-directed or routine tied to the resident's past (i.e. worked 3rd shift, taking long walks or seeking someone they cannot find)? - "No."</p> <p>Is the resident at risk for elopement/wandering at this time? If yes, explain why. - "yes, redirected and returned to unit."</p> <p>Care plan for focus/problem area cognitive loss-impaired cognition related to Dementia as evidenced by hoarding (initiated- 7/29/11). Interventions include but are not limited to: monitor for changes, explain each activity or care procedure, gently redirect activities when resident makes inappropriate actions. The intervention establish a routine/provide consistent caregivers was initiated - 10/4/14. A new intervention added 8/13/15 wanderguard at all times. Check placement every shift.</p> <p>There was no specific care plan focus/problem area developed for elopement risk. Staff were utilizing the behavior/intervention monthly flow record sheets to monitor and document on hoarding behaviors, inappropriate sexual behaviors, and other behaviors. These behaviors were charted on every shift but there was no flow record sheet implemented to track and trend exit seeking behaviors.</p> <p>8/14/15 at 3:08 AM - nursing progress note- Resident has been awake and wandering halls all</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>of this shift. Stating "I've got to go home. " " I'm having a baby tonight. " Noted to attempt to open the exit doors numerous times this shift, easily redirected. " At one point this shift, noted that resident had removed wanderguard from her ankle and was carrying it in her hand." Wanderguard replaced.</p> <p>8/15/15 to 8/27/15 - nursing progress note- no exit seeking behaviors, however , on 8/18/15 at 2:30 PM, R2 was observed to be ambulating around the Unit and later observed close to an exit door talking to another resident.</p> <p>8/31/15 at 22:45 [10:45 PM]-MAR showed that the nurse had documented that R2 received an as needed medication- Ativan 0.5 mg (order is for 1 mg) for "anxiety and exit seeking" behaviors .</p> <p>9/12/15 - Observation Report- Quarterly Assessment - Risk of Elopement/Wandering Review sheets completed by nursing documented the following [These are yes or no answers with some comments]:</p> <p>Is the resident cognitively impaired with poor decision-making skills? - "yes."</p> <p>Has the resident expressed a desire to go home, packed belongings to go home or stayed near exit? - "yes."</p> <p>Is the wandering behavior a pattern, goal-directed or routine tied to the resident's past (i.e. worked 3rd shift, taking long walks or seeking someone they cannot find)? - "yes."</p> <p>Is the resident at risk for elopement/wandering at this time? If yes, explain why . - yes, the resident says is "leaving or has to go home several times a week ."</p> <p>MOS completed 9/21/15 documented the following :</p> <p>BIMS score - 03 - means R2 is severely cognitively impaired</p> <p>Signs and Symptoms of Delirium - fluctuates</p>	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 C 05/06/2016
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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 323	<p>Continued From page 11</p> <p>(comes, and goes, changes in severity) Inattention - has difficulty focusing attention, easily distracted, out of touch or difficulty following what staff said. Disorganized thinking - rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. 9/25/15 at 22:45 [10:45 PM] MAR indicated that R2 received an as needed medication - Ativan 1 mg. The nurse documented that the medication was given for "anxiety and exit seeking" behaviors.</p> <p>The nursing progress notes - showed there were no entries at all for the entire month of September 2015, despite the administration of medications for exit seeking behaviors. This was confirmed in an interview with E3 [ADON] on 5/5/16 and with E4 [RNAC] on 5/6/16 at 9:10 AM. 10/2/15 nursing - At 6:05AM went to give medications to the resident's roommate and saw that R2 was not in his/her bed. Checked the bathroom. At 6:08 AM talked to the CNAs and asked if they had seen R2. The response was no. Started checking other rooms at 6: 10 AM. At 6:20 AM, notified the other nurse that the resident was missing. Continued the search. At 6:25 AM, the other nurse let the Supervisor know that the resident was missing and a code orange was called. At 6:32 AM, " I found out that the exit door on Lighthouse when I pushed it the door opened and the alarm went off. I immediately ran down the hallway to the other exit door and the door opened and it does not have an alarm." At 6:34 AM, immediately let the supervisor know that this door was not secure. Immediately had staff search outside. The doors on the Unit were not checked for at least 20 minutes after the search began.</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>A written statement not dated documented the following: E10 (CNA) found the resident after searching the neighborhood around 7:05AM. The resident was on a front porch. The resident was wearing a long cotton night gown, socks and shoes. E10 gave the resident her jacket and helped the resident into the car. The resident was able to walk to the car and the resident told E10 that R 2 was cold. Arrived back at the nursing facility around 7:14 AM. Nurses and aides responded immediately and removed wet clothing and wrapped the resident in blankets. The facility Event Report started on 10/2/15 at 6:25 AM and completed at 9:28 AM showed that when the resident was brought back to the facility by E10, the resident was answering to her name, wet clothing removed, warm blankets and oxygen applied, vital signs taken, incontinence care provided and 911 called. "Resident was cold to touch." Axillary temperature was 97.1, pulse 100 and unable to get a blood pressure. Transferred to the emergency room for evaluation and treatment. Hospital Emergency Flow Sheet Record reflected that on 10/2/15 the following vital signs were taken: 7:53AM - blood pressure (BP) -99/55, pulse (P) 99, respirations (R) 20, rectal temperature (T.) 92.9. Normal rectal T 99.6 F. Received immediate treatments which included but were not limited to: warming blanket, warmed-up saline infusion bolus and warmed bladder irrigation. 8:19 AM - 8:45 AM vital signs were closely monitored. R2's rectal T. ranged from 93.2 to 93.4 9:00 AM to 11:00 AM rectal T. range was 95 to</p>	F 323		
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F 323	<p>Continued From page 13 98.6.</p> <p>Hospital History & Physical records from 10/2/15 documented the following: Presenting Chief Complaint: "Found outside in the rain from nursing home, presented with hypothermia, shivering and leg cramps." "After aggressive treatment with heating blankets, warmed-up saline infusion bolus and warmed-up bladder irrigation patient's initial core temperature of 92 degrees Fahrenheit (F) went up to 95 degrees F." The patient was admitted to acute care inpatient level of care with further treatment for accidental hypothermia and exposure. In addition, the patient received intravenous antibiotics for an acute urinary tract infection. 10/5/15 Hospital Discharge Documentation indicated the following: Discharge Diagnoses included but were not limited to Accidental Hypothermia (resolved), Urinary Tract Infection, and Advanced Dementia with episodes of delirium.</p> <p>Post Incident documents: 10/2/15 (after the elopement incident) - EB's (CNA) written statement documented that she redirected the resident back to the bathroom in his/her room around 2:30 AM. R2 had stated to the staff person that she was going to have a baby. R2 was outside of room 354 (near the North Exit door) which had the magnetized lock system but no audible alarm at the time of the incident. EB said she did watch the resident walk back to the other hallway but did not see R2 go into the room. 10/2/15 - facility's timeline of the elopement event showed that EB had seen R2 at the nurse's</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>station then walking toward his/her room around 4 :00 AM- 5 :00 AM. The facility did not have a consistent informal or formal system of how often visual checks were to be done for residents on the Lewes Unit at the time of the elopement. 10/2/15 Facility timeline documented that the Administrator checked the distance of where the resident was found by staff. The distance was 0.28 of a mile.</p> <p>The facility inspection and/or invoice records regarding the fire, security and alarm system were reviewed during the on-site survey ending 5/6/16. The magnetic door locks and/or alarms on the Lewes Unit were checked on 5/3/16 and again on 5/5/16 .</p> <p>5/3/16 at 10:40 AM interview with E11 UM-RN confirmed that the exit door by room 314 & 315 had always had an alarm and she showed the surveyor that the door was locked by pushing on it. It requires a key to disalarm and the nurse that works this hallway has the key. E11 had not been on staff at the facility at the time of the elopement.</p> <p>5/3/16 at 10:50 AM interview and tour- E5, the Maintenance Director showed the surveyors the power supply area where the equipment malfunction occurred on 10/2/15. There was a loose wire at the power supply panel that had been repaired according to E5.</p> <p>5/3/16 interview at approximately 11:10 AM, E1, the Administrator stated that on 10/2/15 when it was discovered that R2 was missing, staff also noted that the magnetic doors to the outside of the facility on the end of each hallway (Lewes Unit) were not locked. The alarm sounded when tested by staff on the South exit door (near rooms 314 & 315) that was unlocked. There was never an alarm on the North exit door which goes directly outside to the community neighborhood .</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>Lewes is a secure Unit with a wanderguard system at the front double doors but no wanderguard system was ever installed at the South and North exit doors.</p> <p>The facility's security/fire/alarm system company had been out on 10/1/15 to "investigate Lewes doors and also to install 2 horn strobe lights in place of the 2 bad ones found on inspection. Replaced dual relay for door release in the power supply and installed horns/strobes (part of the fire alarm system). All systems were tested and working at the time of departure. 10/2/15, invoice documented that the security/fire/alarm company came out - found 2 doors in the Lewes Unit had no power to the magnetic locks. Found a loose wire in the power supply terminal. Re-connected the wire and the power was restored to the doors. "Tested power supply battery back-up." Batteries were low and were replaced. One invoice documented battery at 10%. This was confirmed with E5 and the security/fire/alarm company owner (E12) during a telephone interview on 5/5/16 at 1 PM.</p> <p>Reviewed inspection reports both by the Fire Marshall and from the facility's company from 1/15/15 through 10/6/15. These reports showed the following;</p> <p>There were multiple deficiencies identified and comments regarding the various systems, however, there was no documentation regarding work done (maintenance work) on the systems except as stated above and as part of the facility's plan of correction mentioned below. The doors, locks, gates and alarms were tested by E5 at least weekly based on documents.</p> <p>The facility "Policy and Procedure to locate missing residents" (revised 8/29/14) in effect at</p>	F 323		

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F 323 Continued From page 16
the time of the elopement was reviewed during the survey. There were no specific timelines for notifications in the policy except to notify the police after 15 minutes of the search. The police were notified at 6:35 AM on 10/2/15, the search started at 6:08 AM. Walkie talkies were to be distributed to the UM/Charge Nurse and any staff working the perimeter of the building. E10 did not communicate to other staff via walkie talkie when she found the resident.
The findings were discussed at exit on 5/6/16 at 2:15 PM - 2:55 PM with E1[NHA], E3 and E2[DONJ] (by telephone).

The facility implemented the following plan of correction:
On 10/2/15 [7:05 AM] - R2 found by facility staff, received immediate care, 911 called and resident transported to the hospital.
10/2/2015 -stationed staff by doors found to be unlocked (de-magnetized), security company called immediately (on-site by 10:00 AM).
An Emergency door alarm was installed on the only unalarmed door in the Lewes Unit by facility maintenance staff.
The security/alarm company inspection of the Lewes Unit was done.
Immediate repairs made to power supply terminal which had a loose wire. Batteries low (at 10%) in power supply back-up which were replaced. Tested all doors and keypads all functioning after repair.
Audit was done of all residents with wanderguards and their care plans were reviewed
Created a binder with paper back-up for each unit of all elopement risk residents, instead of a master and computer program. This will be audited weekly with updates as needed.
Ordered audible alarms. Until installed every 15

F 323

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F 323	Continued From page 17 minute checks on the doors remained in effect. Alarms installed on 10/5/15. 10/6/15 - all magnetic lock relays had a power failure notification pathway to be jumped to fire panel, permit submitted to Fire Marshall for approval. All wanderguards were placed on generator, post battery back-up as well as all magnetic locks.	F 323		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

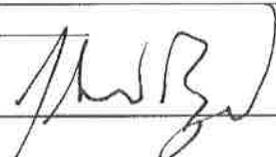
DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: May 6, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<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 complaint survey was conducted at this facility from May 3, 2016 through May 6, 2016. The deficiencies cited in this report are based on record reviews, staff interviews, and review of other facility documentation as indicated. The census the first day of the survey was 160. The sample size included four (4) active and three (3) closed records.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 6, 2016: F166, F272, F279, and F312.</p>	<p>Cross refer to CMS 2567-L, received on May 20, 2016.</p> <p>Related Plan of Correction for the above addresses: F-166, F-272, F-279, and F-312.</p> <p>This plan of correction received on May 20, 2016, 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>	

Provider's Signature  Title Deputy Home Administrator Date May 27, 2016 Rev. June 15, 2016



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

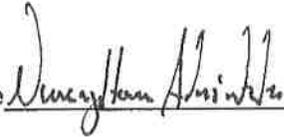
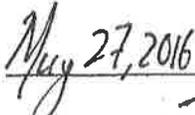
DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: May 6, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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Provider's Signature  Title  Date  Rev. 