

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

PRINTED: 05/27/2016
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2016
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NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from May 9, 2016 through May 13, 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 twenty nine (129). The stage 2 survey sample thirty three (33).</p> <p>Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; ADLs - Activities of Daily Living, such as bathing and dressing; PRN - As needed; MAR - Medication Administration Record eMAR - Electronic Medication Administration Record (In the computer); eTAR - Electronic Treatment Administration Record (in the computer) MDS - Minimum Data Set (standardized assessment used in nursing homes); AIMS (Abnormal Involuntary Movement Scale) - test to measure body movements the resident cannot control, side effect of antipsychotic medications; Antidepressant - drug to treat depression (i.e., Cymbalta);</p>	F 000	<p>Disclaimer Preparation and/or execution of the plan of correction does not constitute an admission or agreement by the provider or the providers employees as to the truth of the allegations in the statement of deficiencies. The plan of correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carolene Paullette</i>	TITLE Administrator	(X6) DATE 6-9-16
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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 Antipsychotic - drug to treat psychosis and other mental/emotional conditions (i.e., Zyprexa, Risperdal); Anxiety- feeling worried, nervous or restless; Cluster - a group of similar infections in people living close to one another; Cognitively Intact - able to make own decisions; Delusion - false belief that is thought to be true; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; Depression - mood disorder with feelings of sadness; GDR (Gradual Dose Reduction) - slowly reducing amount of medication; Glaucoma - eye disorder leading to vision loss; i. e. -that is; Meal set up - place meal and utensils on table, uncover containers, add condiments and cut up food to prepare for eating; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Paranoid - extreme fear or distrust of others; pre-before; post-after; Psychiatric - treatment of mental disorders; Psychosis/psychotic - loss of contact with reality; Psychotropic - drug to treat psychosis and/or other mental/emotional conditions; Pulse - the number of times the heart beats in one minute; Risperdal-medication used to treat certain mental /mood disorders; UTI (Urinary Tract Infection) - urine infection; Zyprexa-medication used to treat symptoms of psychotic conditions.	F 000			
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242			

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F 242 SS=D	<p>Continued From page 2 MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined for one (R92) out of 33 sampled residents the facility failed to actively seek information regarding the resident's preferences for bathing, bed time or time to get up in the morning. Findings include:</p> <p>Review of R92's clinical record revealed:</p> <p>2/14/13 - Care plan problem for cognitive function (last revised 5/2/16) included interventions to keep daily routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion.</p> <p>4/29/13 - Care plan problem for ADL level (last revised 5/2/16) included interventions bathing - total assistance, dressing with assist of one staff, encourage independence, transfer assist with two staff.</p> <p>8/17/15 - MDS significant change assessment documented it was very important for the resident to choose own bedtime as well as to choose between tub, bed, sponge bath or shower. The MDS assessment preferences did not address</p>	F 242	<p>A. RNAC updated Care plan and Quick Care 7/11/2016 Reference to reflect (R92) preferences for bathing, bed time and time to get up in the morning.</p> <p>B. Resident choices to be discussed at weekly care plan meetings for next 4 weeks to ensure that resident preferences are addressed in each resident's individualized care plan. Any identified choices will be noted on the Inter-Disciplinary Care Plan Conference Team Note, hereafter referred to as IDT note.</p> <p>C. IDT note will be updated to include resident choices to be discussed at each care plan meeting on admission, readmission, quarterly, and significant change. Resident preferences identified will be reflected in updated care plan.</p> <p>(See attachment A)</p> <p>D. An audit done by RNACs will be completed weekly x 4 and then monthly x 3 on all resident's IDT note to ensure any resident specific choices have been care planned and made available to staff.</p> <p>(See attachment B)</p>	

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F 242	<p>Continued From page 3 getting up in the morning.</p> <p>5/3/16 - Quarterly MDS assessment documented the resident was cognitively intact and required extensive assistance for bed mobility, transferring in/out of bed and personal hygiene. R92 is totally dependent on staff for bathing.</p> <p>During the stage 1 resident interview on 5/9/16 at 10:45 AM, R92 responded negatively to the following four questions about choices and expressed hesitation about confronting staff about her preferences:</p> <ul style="list-style-type: none"> - Do you choose when to get up in the morning? (would like to get up around 7:00 AM before breakfast, but "they get me up sometimes as late as 10:30 AM") - Do you choose when to go to bed at night? (would like to go to bed around 8:30 PM, but sometimes "they put me to bed around 7:00 PM") - Do you choose how many times a week you take a bath or shower? (scheduled for a shower twice a week with a bedbath on all other days) - Do you choose whether you take a shower, tub, or bed bath? (would like to have a shower only "when I need to wash my hair" - once every other week) <p>During an interview with E6 (RN, UM) on 5/11/16 at 1:35 PM to discuss showering, E6 responded that showers are scheduled according to room number unless a resident or family requests otherwise. E6 confirmed the facility had no formal process for assessing resident preferences for bathing, time for getting up in the morning or bedtime. E6 stated if a resident refused a shower repeatedly, we would look into it for a change in schedule. The nurse stated that R92 usually does not refuse her shower. E6 stated that the</p>	F 242	

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F 242	Continued From page 4 aides should know what schedule the resident likes to keep regarding getting up and going to bed. 5/11/16 - Resident Care Quick Reference (printed on a daily basis) in the CNA assignment binder did not include resident time preference for getting up in the morning or going to bed at night. March 2016 through May 2016 - Review of CNA documentation for bathing showed the resident refused a shower and received a bedbath instead on three (March 16 and 26, April 6) out of 17 scheduled showers. On 5/12/16 at 8:40 AM E6 informed the surveyor that R92's team conference was today and the aforementioned issues would be discussed. During an interview with R92 and her daughter on 5/12/16 at 12:40 PM the daughter said getting up and going to bed times and shower frequency were discussed at the team conference meeting today. 5/13/16 - Review of the Care Plan Conference Team Note dated 5/12/16 found no evidence of the discussion about resident preferences. There was no evidence that the facility actively sought information from R92 for preference in bed and getting up in the morning times or shower frequency until the issue was brought to their attention by the surveyor. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/13/16 at 1:40 PM.	F 242			
F 256	483.15(h)(5) ADEQUATE & COMFORTABLE	F 256			

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F 256 SS=E	Continued From page 5 LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by Based on observation and interview it was determined that the facility failed to maintain adequate lighting in four (R1, R2, R3, and R4) out of 12 rooms on the Rehabilitation Unit. The night lights were not illuminated in these rooms. Findings include: During an interview on 05/09/16 at 1:48 PM, R 223 (room R2) stated that there was no night light in his room. During an environmental tour on 05/12/16 at 11:00 AM, night lights were not illuminated in rooms R1, R2, R3 and R4. During an interview on 05/13/16 at 10:35 AM, E1 (NHA) confirmed that there were no functioning night lights in rooms R1, R2, R3 and R4. The night lights were controlled by a switch at the nurse's station, and this light switch was not turned on at night. These findings were reviewed with E1 and E2 (DON) on 5/13/16 at 1:40 PM.	F 256	7/11/16 A. Night lights illuminated in rooms R1, R2, R3, R4. On/Off switch for night lights deactivated. Night lights permanently on at all times. Switch plate removed. All Staff to be educated on : *night lights to be on at all times *Maintenance will be notified of any lights that need repair. *If repair needed, Maintenance slip to be given to Maintenance for repair. B. Audit of all rooms to be completed for non-functional night lights. C. House keeping (TISK) will check rooms daily when cleaning resident rooms. (See Attachment C1-C6) D. Director of Housekeeping to audit daily x 14 days and then weekly x 4 weeks, and then monthly. (See Attachment D) Audit finding to be reported to Quarterly QA Meeting.
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	F 272	

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F 272	Continued From page 6 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; 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. This REQUIREMENT is not met as evidenced by Based on record review and interview it was determined that the facility failed to ensure the	F 272			

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F 272	Continued From page 7 accuracy of the comprehensive assesment in the area of oral/dental status for one (R47) out of 33 sampled residents. Findings include: Review of R47's clinical record revealed: 2/11/16 - Annual MDS Assesment, in the area of oral/dental status, assessed R47 as having none of the following present: no broken or loosely fitting dentures; no natural teeth or tooth fragments; no obvious or likely cavity or broken natural teeth. 2/12/16 - Quarterly oral health assessment was completed on R47 and broken or loosely fitting denture and chipped, cracked, loose or uncleanable were identified. During an interview on 5/9/16 at 10:35 AM, R47 reported having problems with his teeth, gums and dentures stating "They have some sharp edges on the end." During an interview with R47 on 5/9/16 at 10:40 AM an observation was made of R47's teeth that revealed spaces between the top row of teeth as if broken teeth, some misshapen teeth with pointed jagged edges and some teeth were discolored gray and dark gray, commonly seen with dental cavities. During an interview on 5/12/16 at 12:32 PM with E4 (RNAC), it was confirmed that R47's oral status was inaccurately assessed. E4 stated "I don't know how I would have missed that on the oral health assessment, when I talked to him, I don't recall him having broken teeth or dental caries [cavities]."	F 272	A. Assessment of Oral/dental status on R47 was reviewed with Responsible Party. Person, no consult to be done unless resident is in pain due to mental status. Review of resident R47 by UM. shows no pain at this time. B. Assessment of each resident's oral health will be completed over 3 months. Any identified oral health concerns will be coded in resident scheduled MDS. C. Facility will complete an oral health assessment on each resident by 7/11/16. MDS, section L, Oral/Dental Status, will be coded accordingly. Care plan will be updated as needed. D. An audit will be completed by RNAC weekly x 4 and then monthly x 3 on all residents' oral assessment in comparison to MDS coding. Review of Audit weekly at "Weekly At Risk Meeting" and Quarterly comparison to MDS coding at Quarterly QA Meeting. (See attachment E) Policy and Procedure for Oral Health Services updated. (See attachment F)	7/11/16

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F 272	Continued From page 8 The facility failed to accurately assess R47's oral dental status on the comprehensive assesment.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by Based on record review and observation it was determined that the facility failed to develop a comprehensive care plan to address strategies to promote independent eating and minimize food spillage and soiled clothing during meal time for one (R92) out of 33 sampled residents. Findings	F 279	A. Intervention added on 5/12/16 to "offer cloth napkin with each meal". Update added to care plan and Quick Care reference to reflect need for staff to encourage resident to be out of bed for meals as tolerated and keep over-bed table with meal tray directly in front of resident due to visual impairment. All staff to be educated: Fall mats to be removed when not in use. B. Resident's individual needs will be reviewed with residents, families, and staff for the potential to be affected by missing approaches to encourage independent eating and reduce food spilling and soiled clothing during meal time. Review for all residents by 7/11/16 the next three months. Any identified individualized needs will be added to current care plan.	7/11/16

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F 279	Continued From page 9 include: Cross Refer F311 Review of R92's record revealed: 4/29/16 - Care plan problem (last revised 5/12/16) for ADLs included interventions that the resident needed meal tray set up, was independent with eating, report changes in ADLs to nurse, and newly added intervention dated 5/12/16 offer cloth napkin with each meal. 5/9/16 - 5/13/16 - Four meal observations found the overbed table was not directly in front of, and close to, R92 on 3 (three) occasions and the resident was not out of bed for 1 (one) of the 4 (four) observed meals. R92's care plan did not address the positioning of the resident (to be out of bed for meals) or the overbed table (to be directly in front of the resident and not on the right side with limited vision, and removal of the roommate's fall mat when not in use). These findings were reviewed with E1 (NHA) and E2 (DON) on 5/13/16 at 1:40 PM.	F 279	C. Audit will be conducted on all residents individualized needs and will be reviewed with residents, families, and staff. Any identified individualized needs will be added to current care plan. D. An Audit by RNACs will be completed weekly x 4 weeks and then monthly x 3 on all residents' individualized needs in comparison to care planning approaches. (See Attachment G) Audits to be reviewed weekly at "Weekly At Risk Meeting" and Quarterly at QA Meeting.	
F 309 SS=D	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.	F 309		

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by Based on record review, interview and review of other facility documentation it was determined that the facility failed to adequately assess one (R 17) out of 33 sampled resident's pain level prior to and/or after the administration of a PRN pain medication on two separate occasions. Findings include: Pain management standards were approved by the American Geriatrics Society in April 2002 included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. An undated facility policy entitled Pain Management included to assess pain any time a PRN medication is requested. If resident is prescribed any routine or PRN pain medication the nurse will document on the MAR as per policy. When administering a pain medication, the nurse will reassess the pain within an hour of administration and document effectiveness on the MAR in order to determine if further intervention is required. Review of R17's clinical record revealed 4/19/13 - Care plan problem for pain (last revised 1/14/16) included the following interventions: pain assessment per protocol, pain flowsheet daily, encourage rest periods, administer and monitor	F 309	A. Assessment of (R17) for pain effectiveness documentation missed prior to and/or post administration. Facility unable to correct the action. B. PRN Pain Effectiveness Flow Sheets to be utilized on all residents to ensure utilization of pain effectiveness process. Nurses to be educated on PRN Pain Effectiveness form. (See Attachment H) C. Audits of PRN Pain Effectiveness Flow Sheet and to be reviewed by QA Director as follows: daily x 14 days and then weekly x 4 weeks. D. QA Director to report findings weekly at "Weekly At Risk Meeting and Quarterly at QA meeting for trends and educational needs. PRN effectiveness Flow Sheets to be discontinued providing that EMAR system for documentation has been ensured to have electronic link default settings for "pain effectiveness value pre and post PRN pain medication administration.	7/11/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2016
NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947		
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F 309	<p>Continued From page 11</p> <p>for effectiveness of medications, monitor for side effects of medications.</p> <p>9/29/15 - Physician order included a PRN pain medication for pain.</p> <p>3/31/16 - Quarterly MDS assessment documented the resident was cognitively intact.</p> <p>March 2016 through May 2016 eMAR review found the PRN pain medication was administered on 4/11/16 and 4/29/16.</p> <ul style="list-style-type: none"> - 4/11/16 (1:41 PM) did not include a pain assessment before or after the administration. - 4/29/16 (8:14 PM) did not include a pain assessment after the administration. <p>During an interview with E5 (LPN) on 5/12/16 at 8 :10 AM to review the process for documenting pain scale assessments in the eMAR, the nurse stated residents requiring a post assessment are highlighted in yellow. E5 added that after clicking on the resident there are three things to enter in the eMAR: pain scale (0 to 10) opens up for the nurse to click the number (alternate non-verbal pain scale available), indicate whether the pain medication was effective or not, then write a progress note.</p> <p>During another interview on 5/12/16 (10:45 AM) E 5 demonstrated how to document post pain assessment in the computer using a numeric scale and showed what the progress note would look like when the pain scale, effectiveness and progress note were recorded.</p> <p>5/12/16 (11:40 AM) - Review of R17's progress notes revealed:</p> <ul style="list-style-type: none"> - 4/11/16: pain medication administered at 11:44 	F 309			

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F 311	Continued From page 13 glaucoma (last revised 5/2/16) included interventions to announce self when entering room and explain procedures; ensure appropriate lighting and consistent object placement (added 5/2/16); keep call bell within reach, maintain; large print books, verbal cueing when necessary. 4/29/13 - Care plan problem for ADL level (last revised 5/2//16) included interventions to set up meal tray; independent with eating, encourage independence; report changes in ADLs to nurse. There was nothing in the care plan about positioning of the table and resident to promote independent eating and to minimize food spillage. 5/9/16 (12:30 PM) lunch observation - R92 was seated in a wheelchair with the overbed table directly in front of her. The front edge of the table was at least 18 inches from the resident's body so R92 leaned forward to reach the food with her fork. 5/11/16 (12:20 PM) lunch observation - The front edge of the overbed table was approximately 14 inches away from the resident forcing the resident to extend her arm to reach her meal. The resident's right eye was only partially open with noticeable haziness to the eyeball. The majority of the table was positioned on the right side, the side with the limited vision. When asked if the food was close enough, R92 pulled the wheeled table an inch or so closer but the table leg was against the front wheels of the wheelchair, preventing the table from getting closer to the resident. R92's right pant leg had fresh, wet circular food stain (3 inches) on her thigh. 5/12/16 (12:35 PM) lunch observation - R92 was seated in her wheelchair with the front edge of	F 311	B. Residents individual needs will be reviewed with residents, families and staff for the potential to be affected by missing approaches to encourage independent eating and reduce food spilling and soiled clothing during meal time. Review all residents with in the next three months. Any identified individualized needs will be added to current care plan. C. Audit will be conducted on all residents Care planned for Visual Impairment and missing approaches for "encourage resident to be out of bed for meals as tolerated" and "offer cloth napkin with each meal" and "keep over-bed table with meal tray directly in front of the resident due to visual impairment" and "encourage independent eating and reduce food spilling and soiled clothing during meal time" as applicable to individualized resident needs. Review of all residents by 7/11/16. Any identified individualized needs will be added to current care plan. (See Attachment G) D. An audit will be completed weekly x 4 and then monthly x 3 on all residents' individual needs in comparison to care planning approaches.	

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F 311	<p>Continued From page 14</p> <p>the overbed table sitting catty corner across her right leg, around 16 inches away from the resident. [Again the table was on the side with the limited vision.] The front wheel of the wheelchair was against the roommate's fall mat which was on the floor between the two beds where the resident was eating. The resident was leaning forward to reach her food. R92 dropped a piece of jello on her shirt as the spoon went from the table, across her lap and chest to reach her mouth. A large piece of jello [most of the jello served] was on the floor between the wheelchair and overbed table, and three pieces of jello were visible on the resident's shirt. The resident used her spoon to remove one piece of jello from her clothing and ate it. R92's daughter, who was present in the room, stated that much of the resident's clothing was stained since R92 often spilled food on herself. R92 stated she could not move her wheelchair "over the bump" (pointing to the roommate's fall mat) to get closer to her table. The surveyor explained that placing the table closer and directly in front of her body could help minimize food spilling. The daughter assisted the resident to reposition the table and wheelchair. When the surveyor asked R92 if she would accept a cloth napkin to tuck into her shirt or place on her lap for meals to protect clothing from spilled food, the resident said yes.</p> <p>During an interview with E5 (LPN) on 5/12/16 at 12:45 PM about how to add the resident's desire for a cloth napkin to tuck in her shirt to protect clothes to the Resident Care Quick Reference used by CNAs. E5 called an RNAC to request the cloth napkin be added to the care reference guide.</p> <p>During an interview with E6 (RN, UM) on 5/12/16</p>	F 311		

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F 311	<p>Continued From page 15</p> <p>at 1:00 PM when asked about placement of fall mats when residents are out of bed, E6 stated that fall mats should be put under the bed when not in use. The surveyor described the observation where the resident was not able to get close enough to her food at meal time due to the location of the fall mat.</p> <p>5/12/16 (2:30 PM) - The fall mat had been removed from the floor between the beds and placed under the roommate's bed.</p> <p>5/12/16 - Care Plan Conference Team Note documented the resident was oriented with occasional confusion. ADL status: requires 1 assist with bed mobility, locomotion, dressing, toileting (2 staff). Required 2 assist with transfers, eats independently, dependent bathing, non-ambulatory.</p> <p>5/13/16 (8:40 AM) - Resident Care Quick Reference, initiated by 5/13/16 day shift CNA aide, included a new entry "Offer cloth napkin for all meals" for R92.</p> <p>5/13/16 (9:00 AM) - R92 observed seated up around 70 degrees in bed with the overbed table directly across her body. The resident said she just finished eating breakfast but no cloth napkin was in sight. The roommate's fall mat was seen on the floor between two beds even though the roommate was up and out of the room.</p> <p>During an interview with E6 on 5/13/16 at 9:30 AM about R92's spillage of food and daughter's comment about staining of clothing, E6 said that the resident should be out of bed for meals. Yet, the resident was not out of bed for breakfast today. When discussing the positioning of the</p>	F 311			

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F 311	Continued From page 16 table being being in front of, and close to, R92, E 6 said she moved the fall mat yesterday. 5/13/16 (11:40 PM) - Observed the fall mat previously on the floor between the two beds during breakfast was now placed up on it's long edge and leaned against the roommate's bed. The facility failed to ensure that R92 was out of bed for all meals and that the table containing the meal was positioned close enough for the resident to see and reach food to promote independent eating and minimize food spillage. These findings were reviewed with E1 (NHA) and E2 (DON) on 5/13/16 at 1:40 PM.	F 311			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329			

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F 329	<p>Continued From page 17</p> <p>contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on record review and interview it was determined that the facility failed to have adequate clinical indication for use and/or for monitoring of antipsychotic medications (i.e., Zyprexa, Risperdal) for two (R52 and R17) out of 33 sampled residents. R52 was started on Zyprexa without adequate indication for use and lacked adequate monitoring. R17 was started on Risperdal without adequate monitoring. Findings include:</p> <p>Facility policy entitled Psychotropic Medication (April 2013) included when resident is prescribed any psychoactive medication behavior monitoring and side effect monitoring will be in place. Behaviors should be specific for that resident and care planned accordingly. If resident requires antipsychotic medications, the risk and benefits should be reviewed with resident and responsible party. These should be documented on the psychotropic medication consent form. The least restrictive alternatives will be attempted i.e., behavior modification, environmental changes, programming. Evaluation of the medications will be reviewed and documented quarterly by the psychotropic drug committee. Dose reductions should be documented in the psychotropic reduction meeting.</p> <p>1. The following was reviewed in R52's clinical</p>	F 329	<p>A. Resident (R52) behaviors clarified as psychosis or aggression and monitoring of both on Behavior monitoring sheet.</p> <p>No baseline AIMS assessment was completed when resident started on Zyprexa. Facility unable to correct the action. Resident (R17) baseline AIMS assessment was not completed when resident restarted on Risperdal. Facility was unable to correct the action.</p> <p>B. Audit of all Residents receiving anti-psychotic medications to assess whether a particular medication is clinically indicated to manage the symptom or condition. Audit to be completed by 7/11/16. Reference list to be provided for nursing staff by pharmacy consultant. Nurses to be Educated on acceptable diagnosis and associated behaviors. QA Director to review all new anti-psychotic medications for appropriate diagnosis, and supporting behaviors.</p> <p>C. Audits to be reviewed weekly at "Weekly At Risk Meeting" x 4 weeks and then monthly x 3 on first Week of the following Month at Quarterly QA meeting.</p>	7/11/16

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F 329	Continued From page 18 record: 9/6/13 - Care plan for behavioral issues revised 3/11/16 pertaining to dementia, depression, anxiety and chronic pain disorder as evidence by getting up without assistance and refusing care and refusing to shower or bathe. 9/7/13 Care plan for anxiety revised 3/11/16 documented the resident exhibited restlessness, agitation, attempting to get up without assistance and insomnia. 9/15/13- Care plan for depression revised on 3/11/16 included the signs and symptoms for hopelessness, sadness and refusing care with the approach added 2/16/16 to administer Cymbalta and Zyprexa for depression as ordered. Monitor for side effects and effectiveness. 1/1/16 - 2/9/16 - Review of progress notes lacked evidence of aggressive and threatening behaviors 2/9/16 at 6:34 PM - A nurse's note documented increased behaviors of yelling, trying to sit on floor, threatening to bite staff. The nurse obtained a urine specimen for testing. The physician was made aware and a verbal order was given for the antipsychotic Zyprexa daily at bedtime. 2/9/16 - eMAR included Zyprexa at bedtime for major depressive disorder. 2/10/16 - Medical Psychiatric Progress Note documented agreement with the use of Zyprexa	F 329	D. Pharmacy consult to review for whether a particular medication is clinically indicated to manage the symptom or condition. Psychotropic Reduction Review done with quarterly. AIMS monitoring flow sheets to be transferred onto EMAR system for documentation providing has been incorporated into the electronic medical record.		

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F 329	Continued From page 19 for aggression. 2/10/16 - Urine collected for testing was noted to grow more than three organisms with a request to repeat test. 2/16/16 - Urine collected for testing was noted to grow more than three organisms with a request to repeat test. 2/23/16 - Urine was collected for testing. On 2/25/16 the urine sample showed signs of bacteria indicating infection and the physician started an antibiotic. There was no evidence in the record that the use of Zyprexa was reviewed after it was determined that the resident had a urinary tract infection at the time the antipsychotic medication was started. 2/2016 - Behavior Monthly Flow Sheet used by nursing documented the use of Zyprexa for the behaviors psychosis and aggression. There was no behavior monitoring being done for psychosis or aggression. 3/2016 - 5/2016 - Social Interaction Form for CNA documentation of behaviors included monitoring for attempting to get up without assistance and refusing care of bath/shower. 3/2016 - 5/2016 - Behavior Monthly Flow Sheet used by nursing documented the use of Zyprexa for behaviors of major depressive disorder and delusions. There was no behavior monitoring being done for depressive disorder or delusions. 3/25/16 - AIMS assessment completed by staff,	F 329			

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F 329	<p>Continued From page 20</p> <p>six weeks after starting the antipsychotic medication instead of when the drug was started.</p> <p>During an interview on 5/12/16 at about 2:45 PM with E7 (LPN) revealed R52 was started on Zyprexa for behaviors of yelling out and that the behaviors had really improved since starting the medication.</p> <p>During an interview with E6 (RN, UM) on 5/12/16 at 9:21 AM to discuss Zyprexa, E6 stated that E7 talked to her the day before and depression was not the right diagnosis. They were going to get the doctor or NP to change it to the behaviors / delusions. E6 confirmed that delusions / aggression were not being monitored as a behavior and she would add it to the monitoring form. It was also confirmed that there was not an AIMS assessment done as a baseline when Zyprexa was started.</p> <p>2. Review of R17's clinical record showed:</p> <p>0/5/13 - Care plan problem for behavior (last revised 3/30/16) included the following interventions: assess other times if refuse care, redirect when resident yells or attempts to get up without assistance, check safety devices periodically, give medications as ordered, verify statements to determine if true.</p> <p>6/5/13 - Care plan problem for anxiety related to dementia with behavioral disturbance, psychosis and mood disorder (last revised 1/14/16) included the following interventions: antianxiety / antipsychotic as ordered and monitor for effectiveness or side effect, psychiatric consult PRN, encourage and support independence, needs time to talk, encourage expression of</p>	F 329		

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F 329	Continued From page 21 feelings August 2014 through January 2015 - eMAR showed the resident received Risperdal for continuous crying and yelling out until discontinuation on 1/25/15. 2/17/16 - Physicians' orders included Risperdal twice a day for delusional psychosis. Review of psychiatric progress notes discovered: - 1/13/16 confusion after move off of rehab unit to Kent unit. - 1/26/16 acute confusion recently completed antibiotics for UTI. - 2/17/16 paranoid delusions, discontinue [name of medication for overactive bladder] that was started 9/21/15 due to psychosis and change to [name of different medication]. - 3/9/16 still with delusions, hope GDR in future - 3/16/16 doing great, back to baseline. In future GDR Risperdal. There was no evidence of a baseline AIMS assessment in the electronic or paper record when the antipsychotic was restarted in February 2016. During an interview with E6 (RN, UM) on 5/12/16 at 10:35 AM to discuss the location and frequency of AIMS assessments E6 obtained a binder from the bookshelf. After looking at each paper in the AIMS binder, E6 confirmed that the last assessment performed was from Feb 2015. During an interview with E8 (Medical Records Clerk) on 5/12/16 at 11:10 AM the surveyor asked E8 to locate any AIMS assessments from 2016. At 2:40 PM E8 informed the surveyor no	F 329	

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F 329	Continued From page 22 additional AIMS assessments were located. During an interview with E6 (RN, UM) on 5/13/16 at 9:30 AM, E6 stated she was pretty sure the AIMS was done, but it must must have been misplaced. Durlng an interview with E2 (DON) on 5/13/16 at 10:15 AM, the lack of baseline AIMS assessment was reviewed. The facility failed to perform a baseline AIMS assessment when R17 was restarted on the antinsvchotic Risperdal.	F 329			
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441			

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F 441	<p>Continued From page 23</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on review of facility documentation and interview it was determined that the facility failed to establish and maintain an Infection Control Program by failing to analyze infection data. Findings include:</p> <p>Review of infection control program documentation from January 2016 to April 2016 revealed a lack of data analysis. Infections were recorded and counted each month, but there was no evidence of data analysis.</p> <p>During an interview on 5/13/16 at 10:45 AM, E2 (DON) confirmed that there was no record of the data analysis performed monthly, including identifying clusters, investigations, corrective actions taken in the infection control records.</p>	F 441	<p>A. Facility unable to correct the action. Will begin for month of May,2016.</p> <p>B. Infection Control data to be analyzed by QA Director. Findings to be reported at "At Risk Meeting" the following month.</p> <p>C. Based upon the Analysis of the Infection Control program interventions such as education or policy change will be implemented.</p> <p>D. Quarterly finding reported to QA Meeting for review.</p> <p>7/11/16</p>

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

PRINTED: 05/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2016
NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 24 These findings were reviewed with E1 (NHA) and E2 on 5/13/16 at 1:40 PM.	F 441			



**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: Harrison Senior Living of Georgetown

SURVEY COMPLETED: May 13, 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>An unannounced annual survey was conducted at this facility from May 9, 2016 through May 13, 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 twenty nine (129). The stage 2 survey sample thirty three (33).</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 13, 2016: F242, F256, F272, F279, F309, F311, F329, and F441</p>	<p>Cross reference to form CMS 2567 dated May 13, 2016.</p>	

Provider's Signature Carlene Proutette Title Administrator Date 6-13-16