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

PRINTED: 02/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085029		02/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	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 000	INITIAL COMMENTS	F 000		
	An unannounced annual survey was conducted at this facility from January 27, 2014 through February 3, 2014. 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 126. The stage two survey sample was thirty-five (35).			
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to enure that the results of the most recent survey was posted in an area accessible to all residents. The facility also failed to post a notice of the availability of the survey results. Findings include: On 1/29/14 at approximately 2 PM - Observation revealed the survey results nor a notice of availability were found in the front lobby or other common areas of the facility.	F 167	F167 1. Survey results were placed in a binder on the desk in the front lobby, accessible to all residents and visitors. A notice of availability was placed on all nursing units. 2. Survey results from here forward will continue to be placed in binder and will remain in the front lobby. 3. All staff will be educated on availability of state survey results and its location and on the notice of availability that was placed on each nursing unit. 4. Front desk staff will ensure binder is in its proper location and has not been moved. An audit will be completed weekly x 4 weeks and then monthly x 3 months on the placement of the notice of availability on each nursing unit and on the proper placement of POC binder. (attachment A) Date of compliance: March 10, 2014	3/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carlene Paulette RN.HSN — TITLE: Administrator — (X6) DATE: 2-24-14

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 fr ng 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 c llowing 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 167	Continued From page 1 On 1/30/14 at approximately 11 AM - Observation revealed there was no notice of the availability of the survey results found on the three residential units or the common areas in the facility. On 1/30/14 at approximately 11:30 AM - Observation of the survey results were found on the Sussex unit to be in a clear plastic holder attached to the wall that was mounted over 4 feet high. This was not accessible to residents confined to a wheelchair. There were no survey results posted in the Rehabilitation unit or common areas of the facility. The Kent unit results were posted in a manner that was accessible to their residents. On 1/31/14 - Interview at 2:45 PM with the Administrator, E1, and Assistant Director of Nursing, E3, confirmed the above observations.	F 167		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify one (R148) resident out of 35 sampled of receiving a new roommate. Findings include: 1. The policy and procedure titled Harrison Senior Living of Georgetown Policy and Procedure Change in Resident Status ; indicates, "Charge nurse / nursing supervisor will notify the	F 247	F247 1. Unable to correct for resident R148. 2. Charge nurse/nursing supervisor/admissions director will notify residents when there is a room change or roommate change. Admissions director will maintain a log of room change notifications and roommate change notifications by month. (attachment B)	3/10/14

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F 247	Continued From page 2 residents [sic] legal representative or responsible party when:" "When there is a change in room or roommate assignment." The progress notes in the electronic record for R148, going back to 6/17/13, have no notes indicating room or roommate was changed or planning to be changed. There was no room or roommate change assessment in the electronic record. The room change occurred on 12/15/13. E1, administrator was unsuccessful in finding any notification of roommate change for R148 in the electronic record and this was discussed with E1 on 1/30/14 at 01:35PM.	F 247	3. Nurses will be educated on the room change and roommate change notification process. (attachment C) 4. An audit will be completed weekly x 4 weeks and then monthly x 3 months to ensure that the log is being maintained and the notifications are occurring. (attachment D) 5. Date of compliance: March 10, 2014	
F 309 SS=E	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 record review and interview it was determined that the facility failed to ensure two (R69 and R45) out of 35 sampled residents received the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being. R69 and R45 were not assessed post pain medication administration using the same scale that was used prior to administering the medication. Findings include:	F 309		

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F 309	Continued From page 3 The pain management standards were approved by JCAHO (currently know as Joint Commission) in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002 which include: -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. The following documentation was contained in the clinical record: 1. R69 had a current January 2014 physician's order that originated on 8/29/13 for Percocet (pain medication) 5-325 mg (milligrams) as needed every eight hours for breakthrough pain. 9/3/13 - Care plan for pain included the goal of an acceptable pain level of 0 within 30 minutes to an hour of pain medication administration. The Percocet was administered on the following dates and times using a 0 to 10 pain scale (10 being the worst pain) prior to administering the pain medication; 1/1/14 9 AM 6 = hurts even more 1/2/14 12:00 AM 6 1/2/14 1:00 PM 6 1/13/14 3:00 PM 6 1/19/14 3:00 PM 6 1/21/14 9:00 PM 6 1/28/14 10:00 PM 8 = hurts a whole lot	F 309	F309 1. Unable to correct for resident R69 and R45. 2. Update was completed in Millennium pharmacy to enable nurses to use the same scale before and after PRN pain med administration. (attachment E) 3. Nurses will be educated on the update in Millennium pharmacy. 4. All PRN medications administered through the Millennium system require effectiveness to be documented by appearing in order maintenance. The system also does not allow the next dose to be given unless effectiveness of prior dose was documented. The new update uses the same scale for both prior and post pain levels. Audit not needed for this process. 5. Date of compliance: March 10, 2014	3/10/14

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F 309	Continued From page 4 The post pain assessment for all the above Percocet administrations were documented as "use of PRN (as needed) medication effective for reason administered". No scale was used to determine the level the pain and if the resident's goal was met. During an interview on 1/31/14 at 1:50 PM with E5 and E6, Registered Nurses (RN) revealed that a pain scale was not being used post medication administration. It was further stated that the facility's electronic medication administration record gives them three choices about effectiveness; effective, somewhat effective, not effective. The pain scale is not included in the post pain medication assessment. These findings were confirmed with E1, Administrator and E2, Director of Nursing on 2/3/14 at 1 PM. 2. The following documentation was contained in R45's clinical record: 10/28/13 - Care plan initiated for pain management documented 2 (on a 0-10 pain scale) as an acceptable level of pain and interventions that included to medicate per physician orders and notify the physician if medication is not effective for pain control. 11/19/13 - Physician order for Morphine (pain medication) oral solution 20 milligrams (mg)/milliliter (ml) give 0.5 ml by mouth as needed (prn) for dyspnea (difficulty breathing) and moderate pain and 0.5 ml under the tongue every 30 minutes as needed for severe pain or	F 309		

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F 309	Continued From page 5 dyspnea. December 2013 - The Medication Record (MR) documented R45 was assessed for pain using a numerical (0-10) level for the pain system and was administered Morphine on the following dates and times: 12/3 at 10:21 AM pain severe 8 12/4 at 9:25 AM pain severe 8 12/11at 1:37 PM pain moderate 6 12/13 at 11:47 AM pain moderate 4 12/15 at 9:47 AM pain moderate 6 12/23 at 1:00 AM pain moderate 6 However, reevaluation of R45's pain after the administration of Morphine failed to use the same numerical level for pain. Instead the facility documented the "use of prn medication effective for reason administered". 1/16/14 - MR documented at 12:00 AM resident given Tylenol 325 mg (pain medication) 2 tablets for mild pain rating of 2. Upon reevaluation of R45's pain the facility documented prn medication effective for reason administered. 1/29/14 - MR documented at 10:34 AM Morphine given for a pain level of 6 and upon reevaluation of the pain the facility documented prn medication effective for reason administered. The facility failed to consistently use the 0-10 pain scale for assessing and reassessing medication to ensure R45's pain was managed at an acceptable level of 2. During an interview on 1/31/14 at 11:30 AM with E2, Licensed Practical Nurse and at 11:50 AM with E3, Registered Nurse Assessment	F 309		

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F 309	Continued From page 6 Coordinator revealed the computer program the facility uses allows the staff to document a numerical value for the pain level when assessing pain prior to pain medication administration. However, it will not allow staff to use a numerical value for reassessing pain levels after the administration of pain medication. E2 and E3 confirmed the facility was using two different pain scales to assess R45's level of pain. These findings were confirmed with E1, Administrator and E2, Director of Nursing on 2/3/14 at 1 PM.	F 309		
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 contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R65) out of 35 sampled residents the facility failed to ensure psychoactive medication (medication that affects the brain functioning, causing changes in behavior, mood and consciousness) was used with adequate indication. Findings include: The facility's policy and procedure titled Psychotropic Medication indicated that when a resident is prescribed any psychoactive medication, behavior monitoring and side effect monitoring will be in place, as documented on the behavior monitoring flowsheet. Review of R65's care plan created and initiated on 2/2/13 for behavioral symptoms relating to anxiety due to psychosis (loss of contact/touch with reality) included targeted behavioral symptoms of R65 attempting to get up or toilet with out assistance; removing safety devices; turning off safety devices; isolating herself and signs and symptoms of paranoia (an unreasonable feeling that people are trying to harm you, do not like you). Interventions included to administer Xanax for anxiety (unpleasant state of inner turmoil) per order and monitor for effects and side effects. R65's current monthly physician's order for January 2014 revealed an order originating on 7/5/13 for Xanax 0.25 milligrams (mg.) by mouth three times a day as needed for anxiety and for	F 329	F329 1. Unable to correct for resident R65. 2. Facility will continue with the behavior monitoring flow sheets. Behaviors will be specific to each resident and care planned accordingly. Nurses will ensure that when an antianxiety medication is administered it is documented on the behavior flow sheet for the specific behavior. (attachment F) 3. Nurses will be educated when administering antianxiety medications they must be administered for specific behaviors as opposed to general anxiety and documented on the behavior flow sheet accordingly. 4. An audit will be completed weekly x 4 and then monthly x 3 on all administered antianxiety medications ensuring that the behavior flow sheets are marked correctly according to the behavior for which the medication was administered. (attachment G) 5. Date of compliance: March 10, 2014	3/10/14

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F 329	Continued From page 8 delusion (false belief or opinion). Review of the December 2013 Medication Record (MR) revealed that R65 was administered the as needed dose of Xanax 0.25 mg. on 12/6/13, 12/9/13, and 12/10/13. Review of the December 2013 Behavior Monthly Flow Sheet (BMFS) documented that R65's targeted behavior symptoms which were being monitored included the same symptoms that were on the above care plan (behavioral symptoms relating to anxiety due to psychosis as exhibited by attempting to get up or toilet with out assistance; removing safety devices; turning off safety devices; isolating herself and signs and symptoms of paranoia). This documentation revealed on 12/6/13, 12/9/13, and on 12/10/13, R65 had no episode of the targeted behaviors. Although R65 was administered three doses of as needed Xanax in December 2013, record review lacked evidence of the specific behavior symptom as an adequate indication for the use of the Xanax. Further review of R65's January 2014 BMFS documented the same targeted behavior symptoms which were being monitored in the previous month, December 2013. This documentation revealed on 1/1/14, 1/23/14, 1/24/14, 1/25/14, 1/28/14, and 1/31/14, R65 had no episode of the targeted behaviors. Review of the January 2014 MR revealed that R65 was administered the as needed dose of Xanax 0.25 mg. on 1/1/14, 1/23/14, 1/24/14, 1/25/14, 1/28/14, and 1/31/14.	F 329		

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F 329	Continued From page 9 Although R65 was administered six doses of as needed Xanax in January 2014, record review lacked evidence of the specific behavior symptom as an adequate indication for the use of the Xanax. Interviews with two Registered Nurses, E8 and E9, were conducted on 2/3/14 at approximately 1:15 PM and 1:30 PM respectively. Both RNs verbalized that if an as needed Xanax was administered, they would document the behavior symptoms (indication) on the BMFS. An interview with E10, Assistant Director of Nursing, on 2/3/14 at approximately 1:40 PM revealed that when an as needed Xanax was administered to R65 in December 2013 and January 2014, the expectation was that the specific behavior symptoms, as an indication be documented on the BMFS. Findings reviewed with E1, Administrator, and E2, Director of Nursing on 2/3/14 at approximately 1:45 PM.	F 329		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368		

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F 368	Continued From page 10 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to ensure that resident group approval was obtained and a nourishing snack was available when dinner and breakfast were scheduled greater than 14 hours apart. Findings include: Review of the meal service times revealed that the dinner meals were delivered to units as follows: - Rehabilitation unit: 4:30 PM. - Kent unit: 5:35 PM and 5:40 PM. - Sussex II unit: 5:10 PM. - Sussex unit: 5:30 PM. Review of the meal services times revealed that the breakfast meals were delivered to units as follows: - Rehabilitation unit: 7 AM. - Kent unit: 7:50 AM and 8 AM. - Sussex II unit: 8:20 AM. - Sussex unit: 7:20 AM. The above meal delivery times allowed for greater than 14 hours between dinner and breakfast. An interview with E7, Food Service Director, on 1/30/14, at approximately 2 PM confirmed that	F 368	F368 1. Meal times have been changed to meet the 14 hour requirement breakfast. (attachment H) 2. Facility will continue with new meal times that were initiated on 1/29/2014. 3. All staff will be educated on new meal times and the regulation that there is to be no more than 14 hours between dinner and breakfast unless each resident is offered a nourishing snack. 4. An audit will be completed weekly x 4 and then monthly x 3 on meal service times. (attachment I) 5. Date of compliance: March 10, 2014	3/10/14

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F 368	Continued From page 11 there was greater than 14 hours gap between meals for residents in the above units. In addition, a nourishing snack was not available for residents other then those on prescribed evening snacks and E7 was unaware of whether or not the resident group had approved the meals times. Findings were reviewed with E1, Administrator, and E2, Director of Nursing on 2/3/14 at approximately 1:45 PM.	F 368		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the kitchen area on 1/27/14 at 11:45AM, it was determined that the facility failed to maintain sanitary food handling ware. Findings include: 1. Two out of ten steam table pans reviewed had food debris on the food contact surfaces. One out of six serving tongs had food debris on the food contact surface. These items were stored in ready to use status.	F 371	F371 1. Steam table pans were cleaned and food debris was removed. Serving tongs were cleaned and food debris was removed. 2. Facility will continue with current cleaning process however ensuring that when complete there is no remaining food debris. 3. Dietary staff will be educated on the proper cleaning process and the need to ensure that all items in the ready to use have no remaining food debris. 4. An Audit will be completed weekly x4 and then monthly x 3 on ensuring that all ready to use items of free of debris. (attachment J) 5. Date of compliance: March 10, 2014	3/10/14

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F 371	Continued From page 12 Findings reviewed with the E7, Food Service Director, as the observations were being made.	F 371		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

NAME OF FACILITY: Harrison Senior Living of Georgetown

DATE SURVEY COMPLETED: February 3, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from January 27, 2014 through February 3, 2014. 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 126. The stage two survey sample was thirty-five (35).	Disclaimer Preparation and/or execution of the plan 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.
3201 **3201.1.0** **3201.1.2**	**Skilled and Intermediate Care Nursing Facilities** **Scope** **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.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report dated 2/3/14, F167, F247, F309, F329, F368, and F371.	Cross reference to CMS 2567-L plan of correction submitted for tags F167, F247, F309, F329, F368, F371

Carlene J. Paulette RN.MSN 2-21-14