

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

PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2016
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6628 LANCASTER PIKE HOCKESSIN, DE 18707		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from January 5, 2015 through January 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 154. The Stage 2 sampled residents totaled 32.</p> <p>Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; MD - Medical Doctor/Physician; NP - Nurse Practitioner; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FSD - Food Service Director; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); CAA's - Care Area Assessments (areas on the MDS that are triggered and then considered for development of care plans); MAR - Medication Administration Record; TAR - Treatment Administration Record; NN- Nurses' Notes; ADL - Activities of Daily Living; EMR - Electronic Medical Record; OT - Occupational Therapy; PA - Physician's Assistant; RNP - Restorative Nursing Program (restorative nursing interventions used to promote the resident's ability to adapt and adjust to living as independently and safely as possible);</p>	F 000			

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

TITLE

(X6) DATE

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.

Levy Beardon, NHA

Administrators

2/24/2015

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F 000	Continued From page 1 PROM - Passive Range of Motion (extent to which a joint can be moved safely with/done by staff; mg - milligrams, A unit of weight; ml - milliliters, A unit of liquid volume or capacity in the metric system, 5 ml equals 1 teaspoon; F - degrees in Fahrenheit; ppm - parts per million, measurement used for concentration of sanitizer mixed with hot water; CVA-Cardiovascular Accident (stroke); Cymbalta-antidepressant medication; Trazadone-medication for anxiety and depression; UM - Unit Manager.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157			

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F 167	<p>Continued From page 2</p> <p>change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to consult with the resident's physician and failed to notify the resident's legal representative or an interested family member when the resident's plan of care was not followed which had the potential for requiring physician intervention for one (R113) out of 32 Stage 2 sampled residents. When R113 failed to receive an anti-depressant medication, Cymbalta, as ordered for 13 days, there was no evidence of R113's doctor or family being notified. Findings include:</p> <p>R113 was admitted to the facility on 8/13/14 with a diagnosis of depression (mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave). R113's doctor ordered Cymbalta, beginning 8/19/14.</p> <p>Review of R113's physician orders for 12/14 revealed Cymbalta was ordered to be given daily.</p> <p>R113 also had psychiatric visits to assess and monitor the resident. On 12/8/14, R113's psychiatric NP noted that the resident had a</p>	F 167	<ol style="list-style-type: none"> 1. R113's Cymbalta has been discontinued and responsible party has been notified. 2. Residents in house were reviewed and no further cases were found. 3. Cymbalta was not received from the pharmacy. A pre-authorization was needed, nurses failed to follow up on the pre-authorization and notification to pharmacy, and physician to receive medications as needed during this period. Nurses were in-serviced 1/8/15 and ongoing to call the physician, pharmacy, Director of Nursing (DON), and responsible party if medication is not available. Responsible party must also be notified for any change in condition/treatment. 4. Unit Manager will audit any change in resident's plan of care and notification of physician and responsible party to follow through at clinical meeting 5 days/week x 90 days. Monday audits will include weekend data review. Results will be communicated to QI x 3 months. 	3/16/15

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F 157	Continued From page 3 major depressive disorder and was on Cymbalta daily as part of the treatment. The plan stated, "...continue current psych (psychiatric) medications as ordered". Review of R113's physician orders for 1/16 revealed Cymbalta was ordered to be given daily. Review of the progress notes from 12/26/14 through 1/7/15 lacked evidence that R113's physician and family were notified that Cymbalta was not available from the pharmacy and the resident did not receive 13 doses of Cymbalta as ordered.	F 157			
F 202 SS=D	In an interview, on 1/8/15 at 1:00 PM, E8 (LPN/UM) confirmed the findings. 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to have the primary physician document a discharge summary for two (R143 and R204) out	F 202			

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F 202	<p>Continued From page 4</p> <p>of 32 Stage 2 sample residents who were both discharged to the hospital. Findings include:</p> <p>1. R143 was admitted to the facility on 11/28/14.</p> <p>On 12/22/14, R143's physician ordered the resident be sent to the hospital to be evaluated for an abscess (accumulation of pus) at his pacemaker (small device placed under the skin near your heart to help control your heartbeat) incision site (a cut into a body tissue or organ made during surgery).</p> <p>On 12/22/14, R143 was admitted to the hospital and discharged from the facility.</p> <p>Record review revealed that there was no discharge summary on the clinical record nor on the EMR.</p> <p>On 1/15/15 at 3:10 PM, E3 (ADON) placed a call in the presence of the surveyor to E17 (Medical Records) and asked if there was a discharge summary for R143? E17 stated that there was. However, the discharge summary, dated 1/9/15, was incomplete. There were blanks in the areas of "Pertinent physical and laboratory findings, Course of treatment, Rehabilitation potential...". The discharge summary failed to note that R143 was discharged to the hospital for an evaluation of a pacemaker abscess.</p> <p>The facility failed to have a complete Discharge Summary for R143. On 1/15/15 at 3:15 PM, findings were confirmed by E2 (DON) and E3.</p> <p>2. R204 was admitted to the facility on 7/30/14 and discharged to the hospital on 8/14/14.</p>	F 202	<p>F-202</p> <p>The discharge summaries for R143 and R204 were completed by the Attending Physician.</p> <p>All records of residents discharged in 2014 and 2015 were reviewed, and those found deficient were corrected.</p> <p>The Medical Records Department will conduct a weekly audit of the charts of all residents discharged from the facility. A list of those charts found not to be in compliance shall be given to the Medical Director and Attending Physician. If found not to be completed within 30 days from date of discharge, a notice of non-compliance shall be sent to the Practice Manager.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon Demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15	

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F 202	Continued From page 5 Review of the "Physician Discharge Summary," dated 8/21/14, revealed that only the "final diagnosis" along with the physician's signature and date were filled in on the document. This summary failed to contain other pertinent information such as: brief history, pertinent physical and laboratory findings, course of treatment, condition on discharge, etc. Review of R204's EMR lacked evidence of a completed Discharge Summary. Findings were acknowledged by E2 during an interview on 1/14/15 at approximately 11 :00 AM.	F 202			
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;	F 272	F272 The MDS's for R116, R169 and R182 were modified to reflect correct coding during survey and modified MDS's were submitted to the State and accepted. All MDS's are being audited by the Corporate RNAC and Facility RNAC to ensure accuracy of coding. Modifications and re-submissions of MDS's done as necessary. All staff involved in the completion of the MDS will be inserviced regarding use of coding that reflects the current condition of residents. As MDS's are being completed, RNAC will audit involved residents medical record to ensure coding that reflects current resident condition. Involved staff will be re-inserviced on the spot as errors are noted. Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstration, substantial compliance, results shall be presented quarterly.	3/16/15	

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F 272	<p>Continued From page 6</p> <p>Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for three (R116, R169 and R182) out of 32 Stage 2 sampled residents. Findings include:</p> <p>The facility's "Resident Assessment/Minimum Data Set" policy, last revised on 6/1/04, stated, "... The assessment will accurately reflect the resident's status...".</p> <p>1. R116's progress note, dated 9/30/14 and timed 8:20 PM, stated, "Patient arrived via stretcher and ambulance ... fracture (broken bone) left femur (thigh bone), had fall 8/23/2014 and was (sic) found at home (sic). 8/26/2014 had surgery on left femur fx (fracture)...".</p>	F 272		

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F 272	<p>Continued From page 7</p> <p>R116's modification admission/readmit MDS, dated 10/7/14, was incorrectly coded "0" for a fracture related to a fall in 6 months prior to admission.</p> <p>During an interview on 1/13/15 at 3:05 PM, E5 (RNAC) confirmed the finding and stated that she would do a modification to correct.</p> <p>2. R169's Progress notes, dated 8/27/14 and timed 11:09 PM, stated, "new adm (admission)... s/p (status post) ... CVA (stroke) ...".</p> <p>Review of R169's History and Physical, dated 8/27/14 stated, "... s/p (status post) hosp (hospitalization) 8/6-8/27 for acute CVA ...".</p> <p>R169's admission/readmit MDS, dated 9/9/14, was incorrectly coded "no" for CVA.</p> <p>The facility failed to ensure that the admission/readmit MDS assessment, dated 9/9/14 accurately reflected R169's status when it failed to code for the active diagnosis of CVA. During an interview on 1/15/15 at 1:16 PM, E5 (RNAC) confirmed the findings.</p> <p>3. R182's clinical record revealed that OT services were received on 6/12/14, 6/13/14, and 6/16/14.</p> <p>R182's annual MDS assessment, dated 6/16/14, was incorrectly coded "0" for the number of minutes of "Occupational Therapy" in the last 7 days.</p> <p>During an interview on 1/14/15 at 9:12 AM, E5 confirmed the findings. The facility failed to ensure that the annual MDS assessment, dated</p>	F 272			

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F 272	Continued From page 8 6/16/14, accurately reflected R182's status. Subsequently, a copy of the corrected MDS was provided.	F 272			
F 278 SS=D	483.20(g) - (J) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, it	F 278	F278 1. The MDS for R182 was modified to reflect correct coding during survey and modified MDS was submitted to the State and accepted. Therapy Services and Restorative Nursing Program designees are responsible for entering number of minutes for respective services to reflect status. 2. The MDS for R169 was modified to Reflect correct diagnosis during survey And modified MDS was submitted to the State and accepted. 3. The MDS for R42 was modified to reflect Correct coding during survey and modified MDS was submitted to the State and Accepted		

Cont F278

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F 278	<p>Continued From page 9</p> <p>was determined that the facility failed to ensure that the MDS assessment accurately reflected the resident's status for three (R42, R169 and R182) out of 32 Stage 2 sampled residents. Findings include:</p> <p>The facility's "Resident Assessment/Minimum Data Set" policy, last revised 6/1/04, stated, "... The assessment will accurately reflect the resident's status...".</p> <p>1A. Review of R182's clinical record revealed a doctor's order, dated 8/21/14, for RNP to provide PROM to her left upper extremity (arm) twice a day for 15 minutes and prolonged stretches and PROM to her left hand/wrist.</p> <p>Review of the Restorative Care Flow Records revealed that R182's received RNP services on 8/28/14 through 9/3/14, except for 8/31/14 when R182 refused.</p> <p>R182's quarterly MDS assessment, dated 9/3/14, was incorrectly coded "0" for the number of minutes of "Restorative Nursing Programs Range of motion (passive)" in the last 7 days.</p> <p>1B. Review of R182's clinical record revealed a doctor's order, dated 10/3/14, for OT services to evaluate and treat 3-4 times a week for 12 weeks.</p> <p>R182's clinical record revealed that OT services were received on 11/14/14, 11/18/14, 11/19/14 and 11/20/14.</p> <p>R182's quarterly MDS assessment, dated 11/20/14, was incorrectly coded "0" for the number of minutes of "Occupational Therapy" in</p>	F 278	<p>Cont F278</p> <p>All involved staff will be inserviced regarding coding of MDS to ensure that MDS reflects the current condition of the resident.</p> <p>All MDS's are being audited by the Corporate RNAC and facility RNAC to ensure accuracy of coding. Modification and re-submissions of MDS's being done as necessary. Repeated errors in coding shall result in progressive disciplinary action.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15	

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F 278	Continued From page 10 the last 7 days. During an interview on 1/14/15 at 9:12 AM, E5 (RNAC) confirmed the findings. The facility failed to ensure that quarterly MDS assessments, dated 9/3/14 and 11/20/14, accurately reflected R182's status. Subsequently, copies of the corrected MDSs were provided. 2A. R189's clinical record revealed active diagnoses that included CVA (stroke). R189's quarterly MDS assessment, dated 11/23/14, was incorrectly coded "no" for CVA . 2B. R189's 90 day (Medicare A) MDS assessment, dated 12/3/14, was incorrectly coded "no" for CVA. The facility failed to ensure that the quarterly MDS assessment, dated 11/23/14 and the 90 day MDS, dated 12/3/14, accurately reflected R189's status when it failed to code for the active diagnosis of CVA. During an interview on 1/15/15 at 1:16 PM, E5 confirmed the findings. 3. Review of the nurse's note, dated 11/20/14 and timed 10:11 PM, revealed that R42 had an unwitnessed fall in her room without injury. The quarterly MDS assessment, dated 12/5/14, stated that R42 had no falls. On 1/13/15 at 4:55 PM, E5 confirmed the findings. The facility failed to accurately code on the 12/5/14 quarterly MDS that R42 had a fall without injury on 11/20/14.	F 278			
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 19707	
(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 279 SS=D	<p>Continued From page 11 COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to ensure that individualized care plans were developed for identified needs for two (R132 and R198) out of 32 Stage 2 sampled residents. For R132, the facility failed to develop a dental care plan. For R198, the facility failed to develop an aspiration (inhaling food or fluid into lungs) care plan. Findings include:</p> <p>The facility's policy entitled, "Updating the Resident's Care Plan", last revised in 1/04, stated, "An individual comprehensive care plan</p>	F 279	<p>1. Care Plan for R132 modified to include triggered dental care as noted on Care Area Assessments (CAA).</p> <p>All Care Plans are being audited to ensure accuracy and inclusion triggered items on CAA and/or explanatory note as to why action will not be taken at that time.</p> <p>Copy of CAA will be given to Unit Managers upon completion of MDS. Five chart audits will be conducted weekly to ensure formulation of appropriate care plans and/or explanatory notes. Repeated non-compliance by staff will result in formal progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8526 LANCASTER PIKE HOCKESSIN, DE 19707		
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F 279	<p>Continued From page 12 that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...".</p> <p>1. On 4/10/14, the annual MDS assessment in "Dental Care" stated that R132 had obvious or likely cavity or broken natural teeth.</p> <p>An oral assessment was done on 4/16/14 which stated that R132 had missing and broken teeth and required total care for oral hygiene. The CAA triggered dental care as a potential problem area and stated that care planning for dental would proceed based on the oral assessment of 4/16/14. The triggered dental care CAA was signed by E5 (RNAC) on 4/16/14.</p> <p>Review of R132's care plans revealed that no dental care plan was developed. On 1/8/15 at 8:40: AM, E6 (LPN UM) confirmed the findings.</p> <p>2. R198 was admitted to the facility on 7/23/14 with a diagnosis of dysphagia (difficulty swallowing).</p> <p>A Speech Therapy (ST) Evaluation and Plan of Treatment, certification period 7/24/14 - 8/19/14, stated "...Presents with high risk of aspiration with increased fatigue as meal continues..." and revealed the following recommendations: Pureed diet; Honey thick liquids; Distant supervision during meals; Upright position or out of bed for all meals, meals to be eaten in dining area; Small, single bites; small, single sips; rest breaks every 3-5 bites.</p>	F 279	<p>2. Care Plan for R198 modified to include Speech Therapy recommendations.</p> <p>All Care Plans are being audited to ensure accuracy and inclusion of adopted recommendations of rehab services. Care Plans being updated as necessary.</p> <p>Five chart audits will be conducted weekly to ensure necessary care plans and interventions are developed. Repeated non-compliance by staff will result in progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15	

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 19707
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F 279	Continued From page 13 Review of R198's care plans lacked evidence that a care plan was developed for R198's dysphagia and risk for aspiration which included the ST's recommendations.	F 279		
F 280 SS=D	On 1/14/15 at 5:00 PM, E3 (ADON) reviewed R198's care plans and confirmed there was no care plan developed for R198's risk for aspiration. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to review and revise the care plan for one (R148) out of 32	F 280		

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F 280	<p>Continued From page 14</p> <p>Stage 2 sampled residents. The facility failed to revise the agitation care plan for R146. Findings include:</p> <p>The facility's policy entitled, "Updating the Resident's Care Plan", last revised in 1/04, stated, "An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... Any significant change in the resident's condition... a change in the resident's emotional or mental condition... will be updated on the resident's care plan...".</p> <p>On 12/17/14, R146 had an incident of yelling at his roommate. This resulted in R146 being seen by the psychiatric NP and medication (Trazadone) being ordered for agitation.</p> <p>An Agitation care plan related to cognitive impairment (mental decline including losing the ability to understand resulting in the inability to live independently), developed on 12/19/14 and revised on 12/23/14, had a goal of agitation/verbal abuse will not occur more than twice a week for 90 days with a target date of 3/10/15. Interventions included to approach in a calm, quiet manner, document behaviors, have another staff member approach if needed, allow time to calm down and then reapproach, offer reassurance, redirect, and sit and talk to resident as able.</p> <p>R146's care plan failed to be revised to include the use of medications as ordered with monitoring for effectiveness and side effects/adverse reactions, and psychiatric consult and follow up as indicated. On 1/15/15 at 10:36</p>	F 280	<ol style="list-style-type: none"> R146's care plan has been updated. Care plans have been reviewed to ensure side effects are part of interventions to monitor resident behaviors. Goals will be reviewed as per interdisciplinary care conference schedule. In-services will be performed on revision and accuracy of care plans to include: development of initial care plans for diagnosis, behaviors, orders, etc. and continue to update and revise all existing care plans. This will be trained and demonstrated in the computer by the ADON with all nurses. Care plans will be randomly audited by UM weekly after conference. Results will be communicated to QI monthly x 3 months. 	3/16/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6625 LANCASTER PIKE HOCKESSIN, DE 19707
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F 280 F 281 SS=D	<p>Continued From page 15 AM, E8 (RN) confirmed the findings. 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined that the facility failed to provide services that meet professional standards of quality for one (R113) out of 32 Stage 2 sampled residents. R113 had no Cymbalta for 13 doses from 12/26/14 through 1/7/15, however, nurses incorrectly signed that the resident received the medication five times. Findings include:</p> <p>The facility's policy, entitled Medication Administration, last revised in 1/04, stated, "... Medications are administered in accordance with written orders of attending physicians... All current medication and dosage schedules... are listed on the MAR... MAR Documentation of medication orders include: a. date and time of administration...".</p> <p>According to Lippincott Nursing Center.com (http://www.nursingcenter.com/Inc), "The 8 rights of Medication Administration" included, "...6. Right documentation - Document administration AFTER giving the ordered medication...".</p> <p>R113 had a diagnosis of depression (mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you</p>	F 280 F 281		

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F 281	<p>Continued From page 16</p> <p>feel, think and behave). The 12/14 physician orders for R113 stated the resident was to be given Cymbalta, anti-depressant medication, daily.</p> <p>Review of R113's progress notes revealed the following: A note on 12/28/14 at 5:54 PM stated, "Cymbalta... medication not available. Pharmacy notified"; A note on 12/27/14 at 5:11 PM stated, "Cymbalta... med (medication) not available. Pharmacy notified".</p> <p>Per the 12/14 MAR, E10 (LPN) incorrectly documented on 12/28/14 that Cymbalta was administered when it was not available.</p> <p>Review of R113's progress notes revealed the following: A note on 12/29/14 at 6:20 PM stated, "Cymbalta... med not available. Pharmacy notified".</p> <p>Per the 12/14 MAR, E11 (LPN) incorrectly documented on 12/30/14 that Cymbalta was administered when it was not available and E12 (LPN) incorrectly documented on 12/31/14 that Cymbalta was administered when it was not available.</p> <p>The 1/15 physician orders for R113 stated the resident was to be given Cymbalta daily.</p> <p>Review of R113's progress notes revealed the following: A note on 1/1/15 at 7:22 PM stated, "Cymbalta... med on order"; A note on 1/2/15 at 6:53 PM stated, "Cymbalta... med not available, pharmacy notified".</p> <p>Per the 1/15 MAR, E10 (LPN) incorrectly documented on 1/3/15 and 1/4/15 that Cymbalta</p>	F 281	<ol style="list-style-type: none"> 1. R-113's Cymbalta has been discontinued after noting no signs/symptoms of depression upon review by both the primary and Psychiatrist on 1/8/15. 2. A review of MARS was conducted to ensure professional standards regarding medication administration have been adhered to. Non-compliant staff disciplined accordingly. 3. Cymbalta was not received from the pharmacy. A pre-authorization was needed, nurses failed to follow up on the pre-authorization and notification to pharmacy, and physician to receive medications as needed during this period. Nurses were in-serviced 1/8/15 and ongoing to call the physician, pharmacy, DON, and family if medication is not available. Family must also be notified for any change in condition/treatment. 4. A weekly random audit of MARS will be performed by the ADON. Results will be reported to QI committee x 3 months. 	3/16/15

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F 281	Continued From page 17 was administered when it was not available. During an observation on 1/8/15 at 1:00 PM, E6 (LPN) unlocked the medication cart and confirmed that there was no Cymbalta on the cart for R113. E6 stated that she had been unaware that R113 was not receiving Cymbalta as ordered from 12/28/14 through 1/7/15. E6 went with the surveyor to the emergency medication system and confirmed that the medications in that system did not include Cymbalta. E6 stated that she did not know why Cymbalta was documented as given on 12/28/14, 12/30/14, 12/31/14, 1/3/15 and 1/4/15 when it was not available. In an interview on 1/8/15 at 1:33 PM, E3 (ADON) stated that she had calls out to the nurses who documented that they administered Cymbalta after 12/26/14 when there was none available. The nurses involved stated the following per written statements regarding incorrectly documenting that Cymbalta was given when there was no medication available: On 1/8/15, E11 stated that the Cymbalta was not sent, was not in the back up supply, and was signed as given in error; On 1/8/15, E10 stated that it was possible that he signed Cymbalta as given in error; On 1/9/15, E12 stated that she signed Cymbalta as given "on accident". The facility failed to follow professional standards of medication administration when there was no Cymbalta for 13 doses and 5 doses were incorrectly documented for R113 on 12/14 and 1/15 MARs as given.	F 281		
F 312 SS=D	483.26(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	<p>Continued From page 18</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> <p>This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interview, it was determined that for one (R42) out of 32 Stage 2 sampled residents the facility failed to provide the necessary services for a dependent resident to maintain good grooming. The facility failed to provide toenail care to R42, which resulted in nails that were elongated and curling around her toes. Findings include:</p> <p>According to the facility's policy entitled "Assistance with Activities of Daily Living: Quality of Care", last revised in June 2014, stated, "...1. Each resident shall be given proper personal attention and care of ... nails ... and the resident will receive the care and services needed because he/she is unable to do their own ADL care independently including ... grooming ...".</p> <p>The quarterly MDS assessment, dated 12/5/14, stated R42 was cognitively impaired (mental decline including losing the ability to understand, resulting in the inability to live independently) and that she required extensive assistance of one staff person for personal hygiene needs.</p> <p>The facility developed a care plan, last revised on 3/31/14, for "self care deficit (... grooming...) r/t (related to) deconditioning and dementia (loss of mental functions such as memory and reasoning</p>	F 312	<ol style="list-style-type: none"> R42 had toe nails trimmed by a podiatrist on 1/16/15. No other resident's adversely affected. All nursing staff to be inserviced regarding assessing nails during showers/skin checks weekly, supportive documentation, cut nails of residents able. If not able, add appropriate residents to the podiatry list for next scheduled visit. Inservice regarding alternative interventions of contacting family, psychologist, etc., to provide encouragement/support, and discussing possible outside interventions. Unit Manager will perform monthly audits on four residents on a weekly basis; this will include: nails visually examined on residents, documentation on skin checks, and progress notes. Podiatry list will be reviewed weekly to ensure they were added to the list. Results will be communicated to QI monthly x 3 months. 	3/16/15

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F 312	<p>Continued From page 19</p> <p>that is severe enough to interfere with a person's daily functioning)." The care plan stated R42 required extensive assistance for ADL's, refuses podiatry (specializes in the care of feet) and to clean and to check fingernails and toenails on Tuesdays and Fridays 7-3 PM shift. In addition, there was a care plan intervention for a Podiatry appointment as needed.</p> <p>Observation on 1/6/15 at 12 PM revealed R42's right foot with elongated, curling toenails. The left foot was not visible at the time.</p> <p>Review of R42's clinical record revealed Podiatry notes dated 12/23/13, 2/24/14, 4/26/14, 6/30/14, 9/8/14, and 11/10/14, which all stated "Refused". The Podiatrist would regularly visit the facility to provide foot care to residents in addition to as needed services.</p> <p>Review of the nurse's notes from 12/27/13 to 1/12/15 revealed only one note, dated 1/20/14 and timed 9:31 AM, where R42 refused podiatry and was educated.</p> <p>The Podiatry note, dated 1/12/15, stated "Refused (nsg/nursing aware)". Review of R42's clinical record revealed lack of evidence of further attempts or alternatives to provide toenail care prior to and after the 1/12/15 Podiatrist visit.</p> <p>Observation on 1/13/15 at 9:48 AM with E7 (RN) revealed R42's toenails were extremely long and curling around the toes on both feet. R42 stated that she does not like people to touch her toes as she was ticklish. R42 also denied toe pain at the present time.</p> <p>In an interview on 1/13/15 at 9:55 AM, E7</p>	F 312		

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F 312	Continued From page 20 confirmed the findings. The facility failed to ensure R42 received the necessary services to maintain good grooming by failing to develop and implement an alternate plan when R42 refused nail care repeatedly because of being ticklish, resulting in her elongated, curling toenails.	F 312		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that for one (R48) out of 32 Stage 2 sampled residents the facility failed to provide appropriate treatment and services to prevent a decrease in range of motion. There were multiple opportunities when the facility failed to consistently and/or correctly apply R48's right palm protector as per her plan of care. Findings include: An Occupational Therapy Discharge Summary, dated 6/3/14 and timed 4:31 PM, stated that R48 "will wear right palm guard at all times except for bathing and exercises". Review of the quarterly MDS assessment, dated 10/15/14, revealed that R48 was cognitively impaired (mental decline including losing the	F 318		

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F 318	Continued From page 21 ability to understand, resulting in the inability to live independently) and required extensive assistance of one staff person with dressing. The following observations were made during the survey: - On 1/5/15 at 4:00 PM, the right palm guard was sitting on R48's tray table and R48 was playing with it; - On 1/8/15 at 11:37 AM, the right palm guard was observed incorrectly applied as it was loose and turned around when R48 was sitting in her wheelchair in the satellite dining room during an activity; - On 1/8/15 at 11:57 AM, R48 was taken back to her room and care provided, however, the right palm guard remained incorrectly applied; - On 1/8/15 at 1:00 PM, R48 was moved back to the satellite dining room for lunch and the right palm guard was loose and incorrectly applied; - On 1/8/15 at 1:55 PM, R48 was returned to her room, sitting in her wheelchair and the right palm guard was loose and incorrectly applied; - On 1/12/15 at 9:07 AM, the right palm guard was not applied; - On 1/12/15 at 10:49 AM, R48 was sleeping in her wheelchair in the activity room and the right palm guard was not applied. Findings were confirmed with E3 (ADON) on 1/13/15 at 9:32 AM. The facility failed to consistently and/or correctly apply the right palm guard on R48, a dependent resident, as per her plan of care.	F 318	1. R48's palm guard was place correctly in/on hand immediately. 2. Residents with appliances were reviewed to ensure they were properly applied and in place. 3. An In-service will be performed for all nursing and restorative staff for proper placement and use of devices are applied as ordered. 4. Five days a week, Restorative Nursing Director will audit and ensure that all residents with ordered interventions for assistive/ preventative devices are in place and signed by nurse. Results will be communicated to QI monthly x 3 months.	
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		3/16/15

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 19707		
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F 333	<p>Continued From page 22</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined that the facility failed to ensure that residents are free of any significant medication errors for one (R113) out of 32 Stage 2 sampled residents. R113 was not administered Cymbalta as ordered for 13 days. Findings Include:</p> <p>Cross refer F281</p> <p>R113 had a diagnosis of depression (mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave). The 12/14 physician orders for R113 stated the resident was to be given Cymbalta medication daily.</p> <p>The psychiatric follow up consult note, dated 12/16/14, stated that R113 was on Cymbalta 40 mg daily for major depressive disorder/generalized anxiety disorder (general term for several disorders that cause nervousness, fear, apprehension and worrying). The plan was to continue Cymbalta as ordered.</p> <p>Review of R113's progress notes revealed the following: A note on 12/26/14 at 5:54 PM stated, "Cymbalta... medication not available. Pharmacy notified"; A note on 12/27/14 at 5:11 PM stated, "Cymbalta... med (medication) not available. Pharmacy notified"; A note on 12/29/14 at 8:20 PM stated, "Cymbalta... med not available. Pharmacy notified".</p>	F 333	<ol style="list-style-type: none"> 1. R113's Cymbalta was discontinued after being reviewed by the primary physician and the psychiatrist after findings of no signs and symptoms of depression. 2. A review was conducted to ensure no other residents were affected. 3. In-services were conducted on 1/8/2015 regarding what to do if medication is not received or unavailable for licensed nurses to administer. Unit Managers are checking daily orders on the PCC dashboard and comparing them to the PCC dashboard list of received medications from Pharmacy daily to ensure all medications have been received as ordered. 4. The ADON will conduct a weekly Audit comparing medications ordered and received weekly. Results will be communicated to the QI in monthly meeting x 3 months. 	3/16/15	

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 18707
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F 333	<p>Continued From page 23</p> <p>The 1/15 physician orders for R113 stated the resident was to be given Cymbalta, an anti-depressant medication, daily.</p> <p>Review of R113's progress notes revealed the following: A note on 1/1/15 at 7:22 PM stated, "Cymbalta... med on order"; A note on 1/2/15 at 6:53 PM stated, "Cymbalta... med not available, pharmacy notified"; A note on 1/5/15 at 6:55 PM stated, "Cymbalta... med not available, pharmacy notified and following up with billing department regarding med being rejected for a refill"; A note on 1/8/15 at 10:05 PM stated, "Cymbalta... med not available, pharmacy notified"; A note on 1/8/15 at 12:05 AM stated, "Cymbalta... med not available, awaiting authorization".</p> <p>Observation on 1/8/15 at 1:00 PM, E6 (LPN) unlocked the medication cart and confirmed that there was no Cymbalta on the cart for R113. E6 stated that she had been unaware that R113 was not receiving Cymbalta as ordered from 12/26/14 through 1/7/15. E6 went with the surveyor to the emergency medication system and confirmed that the medications in that system did not include Cymbalta. E6 confirmed that R113 failed to received 13 doses of Cymbalta as ordered by her physician.</p> <p>The facility failed to ensure that R113 was free of any significant medication errors when Cymbalta was not administered as ordered from 12/26/14 through 1/7/15, for a total of 13 days. In an interview, on 1/8/15 at 1:33 PM, E3 (ADON) confirmed the findings.</p>	F 333		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 24</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documentation and interviews, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include:</p> <p>1a. An observation during the initial tour of the kitchen with E13 (FSD) on 1/5/15 at 8:24 AM revealed there was no sanitizer bucket readily available at the cooking/plating station. The bucket was observed sitting empty on a shelf next to the 3-compartment sink (washing station connected to a sanitizer pump used for disinfection of surfaces). E13 immediately removed the bucket from the shelf and filled it at the 3-compartment sink.</p> <p>1b. At 8:26 AM on 1/5/15 with a specialized test strip, E13 checked the concentration of the sanitizer water in the bucket for the cooking/plating station. The unexpired test strip did not register the required minimum of 150 ppm (parts per million) of concentration of sanitizer. E13 tested the water a second time with another test strip. Again, the second unexpired test strip</p>	F 371	<p>1. Service company called, dispenser repaired on 1/15/15. Sanitizer buckets filled, and dietary staff in-serviced on the spot regarding proper use and proper concentration of sanitizer.</p> <p>All dietary staff formally in-serviced use of sanitizer buckets and how to test concentration of sanitizer. Compliance will be monitored daily by Food Service Director (FSD), or designee. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Sanitizer solution to be tested 3 times a day and results will be recorded; if required, vendor will be called for service.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15	

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F 371	<p>Continued From page 25</p> <p>did not register the required minimum concentration of sanitizer. It was at this time E13 confirmed that there was a problem with the sanitizer equipment at the 3-compartment sink.</p> <p>1c. At 8:37 AM on 1/5/15, E13 tested the water in the sanitizer bucket at the plating station in the small room off the kitchen. The unexpired test strip did not register the required minimum of 150 ppm of sanitizer concentration. At this time, E13 stated that he will call the equipment vendor immediately to evaluate the 3-compartment sink sanitization equipment.</p> <p>At approximately 8:40 AM on 1/5/15, E15 (Cook) showed the cooking station's sanitizer bucket's test strip registering 150 ppm to the surveyor and stated that "you have to play with the equipment".</p> <p>As a follow-up, the equipment vendor arrived at the facility on 1/5/15 at 11:47 AM and replaced the metering tip and the hose that pulled the sanitizer from its container and connected to the central pump at the 3-compartment sink. At this time, E13 confirmed that the equipment malfunctioned.</p> <p>2. The facility's undated policy entitled, "Food and Supply Storage Procedures", stated, "... Dry Storage ... Date and rotate items ... Store bulk materials in ... approved containers that have light fitting lids ... Refrigerated Storage ... Date and rotate items ... Discard leftovers not utilized within 48 hours ...".</p> <p>Observations on 1/5/15 at approximately 8:45 AM of the refrigerator and the dry food storage area revealed the following expired or undated foods:</p>	F 371	<p>2. Expired or undated items were immediately discarded. Invoice for top round produced to prove arrival date.</p> <p>All dietary staff formally in-serviced regarding proper labeling and dating of items, and the discarding of expired items. Opening and closing checklists revised to reflect daily review of items.</p> <p>Food Service Director (FDS), or designee, to monitor dietary staff, audit checklist daily and spot check items for compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15

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F 371	<p>Continued From page 26</p> <ul style="list-style-type: none"> - Small portion of pureed bread in a steel container dated 1/1/15-1/4/15 was expired; - Two cups of pears and one pureed pear sitting on a steel tray on a cart in the refrigerator were undated; - Six chef salads and one chicken salad sitting on a steel tray on a cart in the refrigerator were undated; - One top round roast, approximately 15 pounds, was undated; - One gallon container of mayonnaise was undated; - Three one-gallon containers of french dressing were undated; - Four five-pound bottles of honey were undated; - One opened and exposed half-bag of parboiled rice sitting on the bottom shelf in the dry storage area was undated. <p>E13 immediately confirmed the findings upon each observation and removed the respective foods from the refrigerator and dry food storage area.</p> <p>3. Observation on 1/5/15 at approximately 9:00 AM of the cooking station (burners and backsplash of the stove) revealed greasy and dirty surfaces. E13 was asked how often was this area cleaned to which he replied, "every weekend". E13 was asked if the area was cleaned over the weekend as it was presently Monday morning on 1/5/15. E13 stated he did not know.</p> <p>4. The facility's undated policy entitled, "Employee Guidelines - Infection Control Practices", stated, "... Use a spatula or tongs ... when handling food ...".</p>	F 371	<p>F371 (continued)</p> <p>3. The backsplash and burners were cleaned immediately.</p> <p>All dietary staff formally in-serviced regarding daily and weekly cleaning of backsplash. Closing checklist and weekly cleaning logs revised to reflect cleaning of backsplash.</p> <p>Food Service Director (FSD), or designee, to monitor dietary staff daily, audit weekly cleaning logs and closing checklist, and spot check for compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15

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F 371	<p>Continued From page 27</p> <p>The facility's policy entitled "Infection Control", last revised 11/2014, stated, "... 7. ... to prevent cross-contamination: handwashing, changing of gloves, or when performing tasks where cross contamination may occur ...".</p> <p>Observations at the plating station in the room off the kitchen serving the main dining room on 1/5/15 revealed the following:</p> <ul style="list-style-type: none"> - At 12:16 PM, observed E16 (Cook) touching utensils with gloved hands then proceeded to pick up a roll with the same contaminated gloved hands. E16 did not have tongs available. E13 provided E16 with tongs at 12:18 PM. - From 12:16 PM to 12:32 PM, observed E16 change gloves occasionally without washing his hands in between glove changes. - At 12:24 PM, observed E16 touching multiple utensils then proceeded to pick up a grilled cheese with the same contaminated gloved hands and placed it on a plate. E16 was then observed going to the door of the main kitchen and touching it then returning back to the plating station without changing his contaminated gloved hands. <p>5. The facility's undated policy entitled, "Tray Line Checklist", stated, "... Temperatures should be taken and recorded. If temperatures are not adequate they should be corrected ...".</p> <p>Review of the meal temperature logs from 12/1/14 through 1/4/15 for the main dining room and kitchen revealed the following:</p> <ul style="list-style-type: none"> - The main dining room was missing temperature 	F 371	<p>4. Proper utensils provided for server By Food Service Director (FSD). Dietary employee formally disciplined regarding violations of infection policy.</p> <p>All dietary staff in-serviced regarding proper use of utensils, and hand washing and glove changing procedures.</p> <p>FSD, or designee, to monitor dietary staff Practices daily. Formal observations of dietary staff in serving areas shall be conducted weekly and results documented on the sanitation audit. Non-compliant dietary staff to be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15

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F 371	<p>Continued From page 28</p> <p>logs for breakfast, lunch and dinner on 12/1/14, 12/2/14, 12/3/14 (breakfast only), 12/4/14, 12/9/14 (lunch and dinner), 12/10/14 (breakfast), 12/12/14, 12/15/14, 12/16/14 (breakfast), 12/17/14 (breakfast and dinner), 12/18/14 (breakfast), 12/19/14 (breakfast), 12/20/14 (lunch and dinner), 12/21/14 (lunch and dinner), 12/22/14, 12/23/14 (breakfast), 12/25/14 (breakfast), 12/26/14, 12/29/14, 12/30/14 (breakfast), 12/31/14 (breakfast), 1/1/15, 1/2/15, 1/3/15 (lunch and dinner) and 1/4/15 (lunch and dinner).</p> <p>A total of 51 temperature logs were missing out of 95 opportunities, which accounted for 54%.</p> <p>- The kitchen was missing temperature logs for breakfast, lunch and dinner on 12/1/14, 12/7/14, 12/20/14, 12/21/14 (dinner), 12/22/14, 12/23/14 (breakfast and lunch), 12/26/14 (dinner), 12/28/14 (breakfast and lunch), 12/29/14 (dinner), 1/1/15 (lunch and dinner), 1/3/15 and 1/4/15.</p> <p>A total of 27 temperature logs were missing out of 105 opportunities, which accounted for 26%.</p> <p>In an interview on 1/5/15 at 2:45 PM, E13 confirmed there were missing meal temperature logs in both the main dining room and the kitchen.</p> <p>6. The facility's undated policy entitled, "Ware washing", stated, "... 2. The Food Service Director insures that all the dish machine water temperatures are maintained in accordance with manufacturer recommendations for high temperature ... machines ... 3. The Food Services Director is responsible for insuring appropriate completion of temperature ... logs as appropriate ..."</p>	F 371	<p>5. Temperature logs reviewed with involved dietary staff. Dietary staff in-serviced on the spot regarding proper completion of logs.</p> <p>All dietary staff formally in-serviced regarding proper method for taking temperature and proper recording of temperature on temperature logs for breakfast, lunch, and dinner. Opening and closing checklists revised to reflect review of temperature logs.</p> <p>Food Service Director (FSD), or designee, to monitor dietary staff daily, audit temperature logs and opening and closing checklists, and spot check for non-compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p>	3/16/15

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F 371	Continued From page 29 On 1/14/15 at 2:07 PM, the plate surface temperature of the hot-water dishwasher was tested using one of two water-proof thermometers provided by the surveyors. The first reading was 145.9 degrees F, which was well below the required minimum temperature of 160 degrees F. At 2:12 PM, a second test was conducted using the second water-proof thermometer provided by the surveyors, which read 147.0 degrees F. Again, this temperature was well below the required minimum temperature of 160 degrees F. The surveyors immediately asked E13 to test the dishwasher temperature of the plate surface with the facilities equipment, i.e. specialized temperature test strips to attach to a plate or a water-proof thermometer. E13 stated he was out of the temperature test strips and did not have an appropriate thermometer. E13 stated that the staff recorded the temperatures by using the outside gauges of the dishwasher, which did not reflect the actual temperature of the plate surface. At 2:26 PM, E13 called the equipment vendor to have them service it immediately. At 3:05 PM, when asked if the hot-water dishwasher had a temperature booster attached to it, E13 stated it did not have a booster. At 3:18 PM, E13 stated that the equipment vendor provides the specialized temperature test strips. When E13 was asked when did he run out of the temperature test strips, he stated that he hasn't had them for approximately 1.5 months.	F 371	6. Temperature registered on Surveyor's Thermometer and facility's thermometer and machine gauge differed. Vendor called for service. Test strips obtained and new waterproof thermometer purchased. These interventions resulted in proper temperatures being registered. All dietary staff formally in-serviced Regarding proper use of thermometer and test strips and recording of temperatures on log. Dietary staff to immediately notify Food Service Director (FSD), or designee, of any temperatures not within proper range. Non-compliant dietary staff will be subject To progressive discipline. Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.	3/16/15
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F 371	<p>Continued From page 30</p> <p>E13 was asked when he had the temperature test strips, how often would he test the dishwasher? E13 stated he usually tested the dishwasher once a week when he had the test strips. E13 stated that the dishwasher was last serviced by the equipment vendor in March 2014. From March 2014 to January 14, 2015, the facility lacked evidence of routine preventative maintenance for the dishwasher by the vendor.</p> <p>At 3:25 PM, E13 stated that the dishwasher does in fact have a temperature booster attached to it.</p> <p>At 3:46 PM, V1 (equipment vendor) tested the dishwasher temperature using the surveyor's water-proof thermometer, which read 158.2 degrees F (allowance of a +/- 1-2 degree difference was acceptable). When asked if V1 had temperature test strips with him to give to the facility, V1 stated "no" and that they would have to be ordered. V1 stated that the earliest the facility could receive them would be next Monday, 1/19/15. In addition, V1 did not have a thermometer for the facility either.</p> <p>At 4:53 PM, two surveyors met with E1 (NHA) and E2 (DON) to discuss the dishwasher, the lack of testing equipment (i.e. temperature test strips and water-proof thermometer) available at the present time and how often the dishwasher was being checked. E1 and E2 stated that they understood the issues.</p> <p>On 1/15/15 at 8:22 AM, E13 stated that V1 was expected to deliver temperature test strips and a water-proof thermometer this morning.</p> <p>At 9:25 AM, one surveyor observed the following sticker on the side of the dishwasher "... minimum</p>	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 19707	
(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 371	<p>Continued From page 31 wash temperature 160 degrees F ...".</p> <p>At 10:15 AM, two surveyors entered the kitchen as V1 arrived. V1 had temperature test strips (expiration date unknown) and his own personal water-proof thermometer from home.</p> <p>The test strip stated, "When Indicator turns black stated temperature has been achieved ... (Indicator box that changed color) ... 160 degree F ...".</p> <p>At 10:20 AM, V1 applied the first test strip on a plate and ran it through the dishwasher. The test strip Indicator box did not turn black but light gray, which indicated that 160 degrees F had not been achieved.</p> <p>At 10:23 AM, V1 was observed adjusting the temperature booster attached to the dishwasher using a screwdriver.</p> <p>At 10:30 AM, V1 applied the second test strip to a plate and ran it through the dishwasher. Again, the test strip Indicator box turned light gray, which indicated that 160 degrees F had not been achieved.</p> <p>At 10:32 AM, E19 (Maintenance Director) stated that he tested the pipe connecting the temperature booster to the dishwasher using an Infrared measuring device. E19 stated that it measured between 182 to 190 degrees F.</p> <p>At 10:37 AM, V1 used his own personal water-proof thermometer and ran it through the dishwasher. The reading was 160.4 degrees F, which met the minimum required temperature of 160 degrees F.</p>	F 371		

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6628 LANCASTER PIKE HOCKESSIN, DE 19707	
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F 371	Continued From page 32 In an interview on 1/15/15 at 10:40 AM, E13 stated he will test the dishwasher daily using a water-proof thermometer and initiate a new temperature log to reflect the testing. Test strips were ordered, however they will not be delivered until next week. Findings were reviewed during the exit conference with E1 and E2 on 1/15/15 at 6:30 PM. E1 stated that the facility purchased several water-proof thermometers from a local retailer earlier that day. The facility failed to store, prepare, distribute and serve food under sanitary conditions as follows: - failed to have a sanitizer bucket readily available at the cooking station on 1/5/14; - failed to have a properly working 3-compartment sink on 1/5/14; - failed to date food in the refrigerator and dry storage area and remove expired food from the refrigerator; - failed to have a clean cooking station on 1/5/14; - failed to properly serve/plate food in the room off the kitchen serving the main dining room as evidenced by observations of gloved hands touching multiple surfaces and picking up food with contaminated gloves; - failed to wash hands between glove changes during the serving/plating process; - failed to have food temperature logs in the main dining room and kitchen; and - failed to have the dishwasher working properly and the appropriate testing equipment readily available. 7. On 01/5/15 at 12:54 PM, an observation was	F 371	7. Intervention provided at the time of infraction. All staff involved in meal service formally in-serviced regarding proper hand washing. Assigned managers will monitor staff during meal service for compliance. Non-compliant staff will be subject to progressive discipline. Assigned managers will report incidents of non-compliance to infection control nurse, or designee, who will review and record incidents. Results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.	3/16/15

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F 371	Continued From page 33 made of E14 (CNA) who picked up a fork from the floor that R139 had dropped. After picking up the fork, E14 failed to wash her hands and went to take another tray from the lunch cart. At 12:56 PM, the surveyor stopped E14 from taking the next tray and informed her of the observation.	F 371		
F 425 SS=E	On 1/5/15 at 12:58 PM, E14 stated, "Your right" referring to picking up the fork from the floor and failing to wash her hands. 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it	F 425		

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6625 LANCASTER PIKE HOCKESSIN, DE 19707
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F 425	<p>Continued From page 34</p> <p>was determined that for one (R113) out of 32 Stage 2 sampled residents, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The pharmacy failed to dispense Cymbalta as ordered resulting in R113 not being administered 13 doses of this antidepressant medication as ordered. Findings include:</p> <p>Cross refer F333, F281</p> <p>R113 had a diagnosis of depression. The 12/14 physician orders for R113 stated the resident was to be given Cymbalta daily.</p> <p>R113's progress notes, dated 12/26/14 at 5:54 PM, stated that Cymbalta was not available and the pharmacy was notified. Progress notes on 12/27 at 5:11 PM and 12/29/14 at 6:20 PM continued to state that R113's Cymbalta was not available and the pharmacy was notified.</p> <p>The 1/15 physician orders for R113 stated the resident was to be given Cymbalta daily.</p> <p>R113's progress notes, dated 1/1/15 at 7:22 PM and 1/2/15 at 6:53 PM, stated that Cymbalta was not available and the pharmacy was notified. This continued through the progress note on 1/8/15 at 12:05 AM which stated that Cymbalta "was not available, awaiting authorization".</p> <p>The pharmacy failed to dispense Cymbalta as ordered for R113 from 12/26/14 through 1/7/15 for a total of 13 missed doses of Cymbalta.</p> <p>On 1/8/15 at 1:33 PM, in an interview, E3 (ADON)</p>	F 425	<ol style="list-style-type: none"> 1. Pharmacy consultant informed of deficiency F425 on 1/29/15. 2. R113's Cymbalta has been discontinued and the family/RP has been notified. Residents in house were reviewed and no further cases were found. 3. Pharmacy consultant will develop an effective system to review all MARS and TARs of all residents. Consultant will review the contract and have available time allowance needed to accomplish the review to ensure compliance of medication orders and medication available and given as ordered. 4. Pharmacy consultant will report monthly on compliance of medication compliance and review at quarterly QI. 	3/16/15
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F 425	Continued From page 35 stated that she spoke with the facility's pharmacy who stated that they were awaiting prior authorization and that may be due to the holidays and R113's insurance company. E3 stated, "That was no reason because we just bill it to the facility and then work it out later".	F 425		
F 441 SS=F	On 1/8/15 at 1:45 PM, in an interview, E1 (NHA) stated that there was no reason that R113's Cymbalta was not provided by the pharmacy. E1 further stated that the facility gets billed, then we get the authorization and the cost of R113's Cymbalta gets billed to the appropriate source. 483.85 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 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	<p>Continued From page 38</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interview, it was determined that the facility failed to maintain an effective infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to consistently analyze data and failed to act as indicated upon the analysis of data. Findings include:</p> <p>The facility policy entitled, "Infection Control", last revised 11/2014, stated, "This facility will assign and (sic.) infection control coordinator to collect data, monitor, analyze and make recommendations. This data will be submitted to the QI (Quality Improvement) committee monthly ... Surveillance data shall be routinely reviewed and recommendations made for the prevention and control of additional cases Infection rates and analysis will be submitted to the quality assurance/improvement committee meetings monthly ...".</p>	F 441	<ol style="list-style-type: none"> 1. Infection control monitoring is being conducted as per protocol/procedure. 2. All residents are currently being monitored for signs & symptoms of infections. 3. The protocol for Infection Control includes tracking and trending, which will be In-serviced to the Staff Educator to ensure adequate tracking, trending, and analysis to develop interventions needed to avoid cross contamination and contain infections in the facility. 4. The ADON will monitor infection control data monthly to maintain trending, analysis and interventions are in place as required. Results will be reviewed by QI monthly. 	3/16/15
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F 441	Continued From page 37 On 1/14/14 at approximately 1:00 PM, the resident infection control logs from January 2014 to December 31, 2014 were reviewed. The infection logs completed monthly included the following areas: - room number; - resident name; - resident admission date; - onset date; - If the infection was community or in-house (nosocomial) acquired; - the infection site; - the pathogen/organisms; - the symptoms associated with the infection; - the treatment for the infection; - If a foley (a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder) was used; - the physician giving treatment; - and any additional comments. In 2/14, there was an infection control report and a bar graph. Although the data was analyzed, it is uncertain how the data was collected for analysis. Some of the information on the facility's log sheets were missing such as room numbers, admission dates, onset date, where the infection was acquired, the infection site, physician name and comments. The lack of this information on the 2/14 infection log sheets could have altered the report that was generated. The months of April through October 2014, a seven month timeframe, lacked evidence that the facility analyzed the data from the infection logs to determine if any corrective actions were warranted to control and prevent infections in the	F 441		

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F 441	Continued From page 38 facility. Additionally, there were no infection control reports for those seven months. In an interview with E3, ADON on 1/14/15 at 1:15 PM, E3 stated that if no infections were identified in that month then there would not be a plan of correction also if there are no infections, there would be nothing to trend. On 1/15/15 at 1:35 PM, E3 stated that since 5/13/13 to 1/15/15, there have been three different people in the position of Staff Development, who were responsible for the Infection Control Program. E3 stated that she also did infection control last month.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R42) out of 32 Stage 2 sampled residents the facility failed to obtain laboratory services to meet the needs of its residents. The facility failed to obtain a Complete Blood Count (CBC/blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia) on 12/18/14 as per the 9/18/14	F 502		

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F 502	Continued From page 39 physician's order. Findings include: According to the facility's policy entitled "Laboratory Services", last revised in January 2004, stated, "The facility will maintain quality laboratory services to meet the needs of its residents on a timely basis ... 2. Laboratory studies will be obtained ... when ordered by a physician ...". A physician's order, dated 9/18/14, stated "... (check) CBC in 3 months". Review of R42's December 2014 MAR revealed that the CBC was signed off as completed on 12/18/14. Review of R42's clinical record revealed the absence of the 12/18/14 CBC laboratory report. In an interview on 1/13/15 at 2:39 PM, E7 (RN) confirmed that the CBC blood test was not done on 12/18/14. The facility failed to obtain laboratory services for R42 on 12/18/14 as per the 9/18/14 physician's order.	F 502	1. R42 refused the CBC x2 and the physician discontinued the order on 1/20/15. 2. Resident's lab orders were reviewed and are being performed as ordered. 3. A form to identify all labs as ordered with dates are logged and tracked to ensure labs are completed, results rec'd and physician notified. This was initiated for each Unit for the Unit Clerk to monitor daily 5 times a week on 1/19/15. Follow up will communicated to unit manages for necessary interventions. 4. Unit Clerk to make sure scheduled labs are completed as ordered. Results will be presented at QI x 3 months.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		3/16/15

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F 514	<p>Continued From page 40</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized for three (R42, R114 and R146) out of 32 Stage 2 sampled residents. Findings include:</p> <p>1A. The 10/14 physician orders for R146 stated that the diet order was consistent carbohydrate diet (diet to help control patients' blood sugar and/or diabetes) with no added salt and liquids were a thin consistency. There was no fluid restriction order during 10/14.</p> <p>The 10/8/14 physician/NP progress note for R146 was inaccurate when it stated that R146 was on "... FR (fluid restriction) 1500 ml (milliliters)/ (per) day - 960 ml dietary, 540 ml nursing...".</p> <p>The 11/14 physician orders for R146 stated that the diet order was consistent carbohydrate diet with no added salt and liquids were a thin consistency. There was no fluid restriction order during 11/14.</p> <p>The 11/5/14 physician/NP progress note for R146 was inaccurate when it stated that R146 was on "... FR 1500 ml/day - 960 ml dietary, 540 ml nursing...".</p>	F 514		

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F 514	<p>Continued From page 41</p> <p>The 12/14 physician orders for R146 stated that the diet order was consistent carbohydrate diet with no added salt and liquids were a thin consistency. There was no fluid restriction order during 12/14.</p> <p>The 12/10/14 physician/NP progress note for R146 was inaccurate when it stated that R146 was on "... FR 1500 ml/day - 980 ml dietary, 540 ml nursing...".</p> <p>In an interview on 1/15/15 at 10:42 AM, E8 (RN UM) stated that R146 was not on fluid restrictions and stated that she would contact R146's physician. On 1/15/15 at approximately 11:35 AM, E8 stated that she spoke with the PA for R146's physician and R146's fluid restriction order was discontinued in 2/14 and was not to be resumed.</p> <p>The physician/NP progress notes for 10/14, 11/14 and 12/14 were inaccurate regarding fluid restrictions. On 1/15/15 at approximately 11:35 AM, E8 confirmed the findings.</p> <p>1B. Review of the Social Services plan of care progress note, dated 12/24/14 at 12:58 PM, inaccurately stated, "No verbal aggression documented in assessment period." This was not accurate since R146 had a psychiatric consult ordered on 12/17/14 with a medication being ordered for agitation.</p> <p>In an interview on 1/15/15 at 10:49 AM, E8 confirmed the findings.</p> <p>2. A physician's order, dated 5/8/14, stated for R42 to have eye exams every 6 months for Seroquel (antipsychotic medication) therapy.</p>	F 514	<p>1. Residents</p> <p>a. R42 clinical records including vision have been addressed to be more complete and accurate.</p> <p>b. R114 clinical record is now accurate and complete after a meeting with hospice to obtain necessary information including hospice binder(s) to be kept on unit with resident chart.</p> <p>c. R146's record is now maintained in accordance with professional standards to include a note to address the discrepancies noted between social services and other staff in describing the resident & fluids restriction.</p> <p>2. No adverse affects are noted with residents after a review.</p> <p>3. Intervention</p> <p>a. Medical records including unit clerks will be in-serviced on policy and procedure for maintaining chart organization.</p> <p>b. All clinical services that document will be in-serviced on importance of accurate documentation.</p> <p>c. Hospice services have been met with and will be providing binders and appropriate, organized documentation to the facility. Hospice service policy was updated 12/2014.</p> <p style="text-align: right;">CON'T</p>	

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8625 LANCASTER PIKE HOCKESSIN, DE 19707	
(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
F 514	Continued From page 42 Review of R42's clinical record revealed an absence of an eye exam consultation as per the 5/8/14 physician's order. In an interview on 1/13/15 at 4:24 PM in the social services office, E3 (ADON) and E18 (SSD) reviewed the social services binder maintained by the former social services director and located the 5/16/14 vision consultation for R42. The facility failed to ensure that R42's clinical record was complete as the 5/16/14 vision consult was located in the social services office in a binder and not in R42's clinical record. 3a. The facility's policy entitled, "Hospice Care", last revised in December 2014, stated, "... Communication ... 2. Nursing staff will ensure ... Hospice documentation is current and available ...". Review of R114's clinical record and hospice binder on 1/15/15 revealed an absence of hospice documentation (specifically nursing assessments/notes) since the election of hospice services on 11/17/14. In an interview on 1/16/15 at 11:21 AM, E8 (RN) confirmed that there were no hospice nurse's notes in R114's clinical record as the hospice organization documents electronically. E8 stated that the hospice nurse communicates with the facility nurse verbally. On 1/16/15 at approximately 9:30 AM, E8 called the hospice organization and requested the nursing notes to be faxed to the facility, which resulted in an 86-page fax that was received approximately three hours after the request was made. The	F 514	CONT 4. a. Four residents' progress notes on residents of high risk behaviors, room changes, or on hospice services will be reviewed weekly to ensure resident records are accurately documented between nurses and interdisciplinary services by DON or designee. Repeated non-compliance by staff will subject them to progressive disciplinary action. b. Audit results shall be presented at the monthly QI meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly. Results will be communicated to QI monthly x 3 months.	3/16/15

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

PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2016
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6626 LANCASTER PIKE HOCKESSIN, DE 19707
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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)	(X5) COMPLETION DATE
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F 514	<p>Continued From page 43</p> <p>facility failed to ensure that R114's clinical record was complete and readily accessible.</p> <p>3b. Review of R114's clinical record revealed that R114 had an unwitnessed fall without injury on 1/6/16. As a result of this fall, R114 was care planned for "frequent safety checks".</p> <p>Review of R114's clinical record revealed the lack of evidence of "frequent safety checks".</p> <p>In an interview on 1/15/16 at 1:45 PM, E8 (RN) stated that safety checks were not being documented as the staff knew to do them. The facility failed to ensure that R114's frequent safety checks were documented when done as per her care plan.</p>	F 514		
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**DELAWARE HEALTH
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STATE SURVEY REPORT

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NAME OF FACILITY: Regal Heights Healthcare & Rehab Center

DATE SURVEY COMPLETED: January 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>An unannounced annual survey was conducted at this facility from January 5, 2015 through January 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 154. The Stage 2 sampled residents totaled 32.</p>	
3201	<p>Regulations for Skilled and Intermediate Care Facilities</p>	
3201.1.0	<p>Scope</p>	<p>Cross-refer to CMS 2567-L survey date completed 1/15/15, F157, F202, F272, F278, F279, F280, F281, F312, F318, F333, F371, F425, F441, F502 and F514.</p>
3201.1.2	<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:</p> <p>Cross-refer to CMS 2567-L survey date completed 1/15/15, F157, F202, F272, F278, F279, F280, F281, F312, F318, F333, F371, F425, F441, F502 and F514.</p>	<p><u>2-301.14</u> Proper utensils provided for server by Food Service Director (FSD). Dietary employee formally disciplined regarding violations of infection policy.</p> <p>All dietary staff in-serviced regarding proper use of utensils, and hand washing and glove changing procedures.</p> <p>FSD, or designee, to monitor dietary staff Practices daily. Formal observations of dietary staff in serving areas shall be conducted weekly and results documented on the sanitation audit. Non-compliant dietary staff to be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;">3/16/15</p>
3201.7.0	<p>Plant, Equipment and Physical</p>	

Provider's Signature Jerry Reardon, MHA Title Administrator Date 2/24/2015



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.5	<p>Environment</p> <p>Kitchen and Food Storage Areas.</p> <p>Facilities shall comply with the Delaware Food Code.</p> <p>Based on the dietary observations during the survey, it was determined that the facility failed to comply with the following sections of the food code;</p> <p>2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 4.</p> <p>3-301.11 Preventing Contamination from Hands. (B) Except when washing fruits and vegetables as specified under § 3-302.15 or as specified in ¶ (D) of this</p>	<p>3-301.11 Proper utensils provided for server by Food Service Director (FSD). Dietary employee formally disciplined regarding violations of infection policy.</p> <p>All dietary staff in-serviced regarding proper use of utensils, and hand washing and glove changing procedures.</p> <p>FSD, or designee, to monitor dietary staff Practices daily. Formal observations of dietary staff in serving areas shall be conducted weekly and results documented on the sanitation audit. Non-compliant dietary staff to be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;"><i>3/16/15</i></p>



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 4.</p> <p>3-304.14 Wiping Cloths, Use Limitation. (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114. (E) Containers of chemical sanitizing solutions specified in Subparagraph (B)(1) of this section in which wet wiping cloths are held between uses shall be stored off the floor and used in a manner that prevents contamination of FOOD, EQUIPMENT, UTENSILS, LINENS, SINGLE-SERVICE, or SINGLE-USE ARTICLES. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 1a to c.</p> <p>3-304.15 Gloves, Use Limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. This requirement is not met as evidenced by:</p>	<p><u>3-304-14</u> Service company called, dispenser repaired on 1/15/15. Sanitizer buckets filled, and dietary staff in-serviced on the spot regarding proper use and proper concentration of sanitizer.</p> <p>All dietary staff formally in-serviced use of sanitizer buckets and how to test concentration of sanitizer. Compliance will be monitored daily By Food Service Director (FSD), or designee. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Sanitizer solution to be tested 3 times a day and results will be recorded; if required, vendor will be called for service.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;">3/16/15</p>



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 4.</p> <p>3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. (B) Except as specified in ¶¶ (D) - (F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if</p>	<p><u>3-304.15</u> Proper utensils provided for server by Food Service Director (FSD). Dietary employee formally disciplined regarding violations of infection policy.</p> <p>All dietary staff in-serviced regarding proper use of utensils, and hand washing and glove changing procedures.</p> <p>FSD, or designee, to monitor dietary staff Practices daily. Formal observations of dietary staff in serving areas shall be conducted weekly and results documented on the sanitation audit. Non-compliant dietary staff to be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;">3/16/15</p>



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NAME OF FACILITY: Regal Heights Healthcare & Rehab Center

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) ingredient or a portion of a refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the</p>	<p><u>3-501.17</u> Expired or undated Items were immediately discarded. Invoice for top round produced to prove arrival date.</p> <p>All dietary staff formally in-serviced regarding proper labeling and dating of items, and the discarding of expired items. Opening and closing checklists revised to reflect daily review of items.</p> <p>Food Service Director (FDS), or designee, to monitor dietary staff, audit checklist daily and spot check items for compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;">3/16/15</p>



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>REGULATORY AUTHORITY upon request. (E) Paragraphs (A) and (B) of this section do not apply to individual meal portions served or repackaged for sale from a bulk container upon a consumer's request. (F) Paragraph (B) of this section does not apply to the following FOODS prepared and PACKAGED by a FOOD PROCESSING PLANT inspected by a REGULATORY AUTHORITY: (1) Deli salads, such as ham salad, seafood salad, chicken salad, egg salad, pasta salad, potato salad, and macaroni salad, manufactured in accordance with 21 CFR 110 Current good manufacturing practice in manufacturing, packing, or holding human food; (2) Hard cheeses containing not more than 39% moisture as defined in 21 CFR 133 Cheeses and related cheese products, such as cheddar, gruyere, parmesan and reggiano, and romano; (3) Semi-soft cheeses containing more than 39% moisture, but not more than 50% moisture, as defined in 21 CFR 133 Cheeses and related cheese products, such as blue, edam, gorgonzola, gouda, and monterey jack; (4) Cultured dairy products as defined in 21 CFR 131 Milk and cream, such as yogurt, sour cream, and buttermilk; (5) Preserved FISH products, such as pickled herring and dried or salted cod, and other acidified FISH products defined in 21 CFR 114 Acidified foods; (6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original CASING on the product; and (7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are</p>	<p><u>3-501.18</u> Expired or undated Items were immediately discarded. Invoice for top round produced to prove arrival date.</p> <p>All dietary staff formally In-serviced regarding proper labeling and dating of Items, and the discarding of expired Items. Opening and closing checklists revised to reflect daily review of Items.</p> <p>Food Service Director (FDS), or designee, to monitor dietary staff, audit checklist daily and spot check Items for compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p style="text-align: right;"><i>3/16/15</i></p>



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 2.</p> <p>3-501.18 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Disposition. (A) A FOOD specified in ¶ 3-501.17(A) or (B) shall be discarded if it: (2) Is in a container or PACKAGE that does not bear a date or day. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 2.</p> <p>4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than: (2) For all other machines, 82oC (180oF). This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 6.</p> <p>4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ¶ 4-703.11(C) shall meet the criteria specified under § 7-204 11.</p>	<p><u>4-501.112</u> Temperature logs reviewed with involved dietary staff. Dietary staff In-serviced on the spot regarding proper completion of logs.</p> <p>All dietary staff formally in-serviced regarding proper method for taking temperature and proper recording of temperature on temperature logs for breakfast, lunch, and dinner. Opening and closing checklists revised to reflect review of temperature logs.</p> <p>Food Service Director (FSD), or designee, to monitor dietary staff daily, audit temperature logs and opening and closing checklists, and spot check for non-compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.</p> <p><i>3/16/15</i></p> <p><u>4-501.114</u> Service company called, dispenser repaired on 1/15/15. Sanitizer buckets filled and dietary staff In-serviced on the spot regarding proper use and proper concentration of sanitizer.</p> <p>All dietary staff formally In-serviced use of sanitizer buckets and how to test concentration of sanitizer. Compliance will be monitored daily by Food Service Director (FSD), or designee. Non-compliant dietary staff will be subject to progressive discipline.</p> <p><i>COIT</i></p>



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	<p>Sanitizers, Criteria, shall be used in accordance with the EPA registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall: (2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 1.</p> <p>4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 3.</p> <p>4-602.13 Nonfood-Contact Surfaces. Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey date completed 1/15/15, F371, Example 3.</p> <p>4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by</p>	<p><u>4-501.114 corr</u> Sanitizer solution to be tested 3 times a day and results will be recorded; if required, vendor will be called for service.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly. 3/16/15</p> <p><u>4-601.11</u> The backsplash and burners were cleaned immediately.</p> <p>All dietary staff formally in-serviced regarding daily and weekly cleaning of backsplash. Closing checklist and weekly cleaning logs revised to reflect cleaning of backsplash.</p> <p>Food Service Director (FSD), or designee, to monitor dietary staff daily, audit weekly cleaning logs and closing checklist, and spot check for compliance. Non-compliant dietary staff will be subject to progressive discipline.</p> <p>Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly. 3/16/15</p>



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Table with 2 columns: SECTION and STATEMENT OF DEFICIENCIES. It contains detailed text regarding hot water mechanical operations, backplash cleaning, and temperature monitoring procedures.

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

4-602.13

The backplash and burners were cleaned immediately.

All dietary staff formally in-serviced regarding daily and weekly cleaning of backplash. Closing checklist and weekly cleaning logs revised to reflect cleaning of backplash.

Food Service Director (FSD), or designee, to monitor dietary staff daily, audit weekly cleaning logs and closing checklist, and spot check for compliance. Non-compliant dietary staff will be subject to progressive discipline.

Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.

4-703.11

Temperature registered on Surveyor's thermometer and facility's thermometer and machine gauge differed.

Vendor called for service. Test strips obtained and new waterproof thermometer purchased. These interventions resulted in proper temperatures being registered.

All dietary staff formally in-serviced Regarding proper use of thermometer and test strips and recording of temperatures on log. Dietary staff to immediately notify Food Service Director (FSD), or designee, of any temperatures not within proper range. Non-compliant dietary staff will be subject to progressive discipline.

Audit results shall be presented at the monthly QI Meeting to ensure compliance. Upon demonstrating substantial compliance, results shall be presented quarterly.

Handwritten date: 3/16/15

Handwritten date: 3/16/15