

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

PRINTED: 04/12/2016
FORM APPROVED
OMB NO. 0938-0391

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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 03/31/2016 |
| NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 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 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from March 22, 2016 through March 31, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical record and other facility documentation as indicated. The facility census the first day of the survey was 159. The Stage 2 survey sample was 32.</p> <p>Abbreviations/definitions used in this CMS 2567 are as follows:</p> <p>NHA- Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN- Registered Nurse; RNAC- Registered Nurse Assessment Coordinator; LPN- Licensed Practical Nurse; CNA- Certified Nurse's Aide; FMD- Facility Maintenance Director; RD - Registered Dietician; UM- Unit Manager; FSD - Food Service Director; AFSD - Assistant Food Service Director; FMD - Facility Maintenance Director; A/C - Air Conditioning; Activities of daily living (ADLs) - tasks needed for daily living, that is dressing, hygiene, eating, toileting and bathing; AFIB-Atrial Fibrillation- irregular heart beat; BIMS-Brief Interview for Mental Status; Care Area Assessment Summary (CAA) - part of the MDS assessment which assists in identifying and planning for potential problem care areas; Cognitive impairment - abnormal mental processes or thinking;</p> | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Kris Perrone NHA 5/26/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | Continued From page 1 Cognition- relating to or involving conscious intellectual activity (as thinking, reasoning, or remembering); Contact Precautions-use of gloves, gowns, hand washing to limit spread of germs; Continent/continence - control of bladder function; Contact guard- hands on person but not give assistance unless needed; Contact precautions-procedures that reduce the risk of infection; CVA-Cerebrovascular Accident, stroke; CHF-Congestive Heart Failure - heart muscle does not pump blood as it should; Diuretic- water pill/medicine that promote production of urine; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Droplet-germs can be spread from the nose, eyes or mouth; EMR - Electronic Medical Record; Excretory-remove excess unnecessary fluid from body; Extensive assist - help with weight bearing support; Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during the review time period; Hemiplegia-paralysis of one side of the body; Halo Bars- grab bar for positioning; IDT - Interdisciplinary Team or care team; Ileostomy - surgical opening of the ileum (small intestine) on the surface of the abdomen; Incontinent - loss of control of bladder and/or bowel function; Limited assistance - resident highly involved in | F 000 | | | |

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| F 000 | Continued From page 2 activity; staff provide guided maneuvering; Microorganisms - an organism that is so small that it is invisible to the naked eye; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Bed Mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture; Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet); Minimal assist - 25% assistance/provides guidance; Limited Assistance - resident highly involved in activity; staff provide non-weight bearing assistance; MRSA - Methicillin Resistant Staphylococcus Aureus/bacteria that is resistant to many antibiotics; Nocturia-waking up in the night to urinate; NN's- nurse's notes; Narcotic- drug that affects the mood or behavior, can be used to decrease pain; Occasionally incontinent - less than 7 episodes of incontinence during the review time period; PPE - Personal Protective Equipment (gown, gloves, mask, and so on); Psychosis - loss of contact/touch with reality; Strep Viridance- group of bacteria comprising different species; Urge incontinence-strong sudden urge to urinate; UTI-bacteria in the urine; UA - urinalysis. | F 000 | F253 Facility failed to provide housekeeping and maintenance services necessary to maintain sanitary, orderly and comfortable interior. A. Deficient practices for the following rooms were corrected: A-11 floor cleaned, caulk around sink repaired, sink adjusted and straightened; A-16 Bath floor cleaned, bathroom fixtures cleaned; A-21 bedroom and bathroom floors cleaned, holes in bathroom wall repaired, bedroom walls repainted, nightstand knob replaced, over bed table cleaned, wheelchair cleaned; A-23 bedroom and bathroom floors cleaned, caulking around toilet repaired, bathroom wall cleaned, bathroom vent dusted, bedroom walls repainted, drywall repaired under window, area under a/c | 5/26/16 |
| F 253 SS=B | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a | F 253 | | |

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| F 253 | Continued From page 3 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/22/16 and 3/23/16 during Stage 1 and during the environmental tour with E4 (FMD) on 3/28/16 between 9:45 AM and 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 17 rooms (A Wing: 11, 16, 21, 23, 26, 31, 32, 33; E Wing: 6, 7, 8; C Wing: 8; B Wing: 12, 16, 17, 24, 25) out of 36 rooms surveyed and 2 dining rooms (A and E wing dining rooms). The following observations were made on 3/22/16 and 3/23/16 during Stage 1 review and during the environmental tour on 3/28/16 between 9:45 AM and 11:00 AM. Wing A Room 11 - The bedroom floor had streak marks at the entrance of the room; - Caulking around sink was in disrepair; - The sink was leaning down on the right side; Wing A Room 16 - The bathroom floor was dirty; - The bathroom smelled like urine; Wing A Room 21 - The bedroom floor and bathroom floor were dirty; - Two holes were in the bathroom wall by the mirror; - The bedroom walls had peeling paint; | F 253 | unit cleaned, nightstand knob replaced, wheelchair cleaned; A-26 bathroom floor cleaned, caulked toilet, wall under window sanded and painted; A-31 toilet cleaned, commode bucket cleaned; A-32 door facing hallway repaired; A-33 bedroom and bathroom floors were cleaned, screws removed, patched and painted, call light cover replaced, a/c unit cleaned, heating unit painted; A-Dining Room a/c units cleaned, window screens replaced, a/c unit adjusted; E-Dining Room/common areas and C- Dining Room/common areas were cleaned, fabric chairs have been replaced on E wing common area, 2 small tables removed; E-6 bedroom wall cleaned; E-7 pull handles replaced, faucet tightened, faucet leak repaired; E-8 a/c unit repaired, closet door hoes repaired, bedroom wall repaired, plaster dust | 5/26/16 |

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| F 253 | Continued From page 4 - The night stand had a knob missing on the third drawer; - The overbed table was dirty; - The wheelchair was dirty; Wing A Room 23 - The bedroom and bathroom floors were dirty; - Caulking around toilet in disrepair; - The bathroom wall was dirty to the right side of the sink; - Vent on the bathroom ceiling was dusty; - Walls in the bedroom around the bottom perimeter had peeling paint; - Wall under the window had chipped drywall; - Area under the A/C unit was dirty with debris; - The night stand had a knob missing on the first drawer; - The wheelchair was dirty; Wing A Room 26 - The bathroom floor around the edges and behind the toilet was not clean; - The baseboard cover was missing on the left side of the bathroom door; - The wall under the window had unsanded patches; Wing A Room 31 - The toilet seat was soiled; - The bucket to catch urine and feces had an area with dried brown material; Wing A Room 32 - The door surface facing the hallway was in disrepair; Wing A Room 33 - The bedroom and the bathroom floors were dirty; | F 253 | cleaned from floor; C-8 a/c unit properly secured; B-12 wall painted, front door painted; B-16 a/c unit repaired, dresser replaced; B-17 a/c unit properly secured; B-24 dresser replaced, a/c vent dusted, floor molding secured, sink drain unclogged; B-25 hole in wall patched and painted, drywall repaired, night stand next to B bed chip repaired, night stand next to A bed handle replaced, a/c unit cleaned, bathroom call light cover replaced, sink unclogged, sink stopper replaced, bedroom was painted, floors cleaned, front door chip repaired, dresser and TV stand replaced. B. All rooms, bathrooms and common areas on all nursing wings will be audited for cleanliness, | 5/26/16 | |

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| F 253 | <p>Continued From page 5</p> <ul style="list-style-type: none"> - The bedroom walls had exposed screws; - The bathroom call light was cracked; - The A/C unit was dirty; - The heating unit along the wall by the window had chipped paint; <p>A Wing Dining Room</p> <ul style="list-style-type: none"> - Both A/C units were dirty; - Two holes were in the window screen; - The A/C unit on the right side of the room was not fitting properly on the wall; <p>East Wing Dining Room</p> <ul style="list-style-type: none"> - There was a urine smell in the dining and other gathering area of Eastburn by Christina wing; - Gathering area of Eastburn by Christina wing had 5 fabric covered chairs that are worn, stained, and in disrepair; - There are 2 small round tables in disrepair; <p>Wing E Room 6</p> <ul style="list-style-type: none"> - The wall at the foot of the bed was dirty; <p>Wing E Room 7</p> <ul style="list-style-type: none"> - The pull handles to drawers were broken off on the first and forth drawer; - The faucet at the resident's sink was loose from the sink. - The faucet was leaking slightly when the water was on; <p>Wing E Room 8</p> <ul style="list-style-type: none"> - The A/C unit was taped on sides and top; - The closet had small multiple holes in the door; - The wall behind the head of bed was in disrepair; - There was plaster dust on the floor; <p>Wing C Room 8</p> <ul style="list-style-type: none"> - The A/C unit was in disrepair; | F 253 | <p>furniture condition, paint condition, a/c unit condition, bathroom fixture condition and call light cover condition to ensure that no other residents are affected by this deficient practice. This will be completed by the Maintenance Director/designee. All findings will be reported to the NHA and promptly corrected..</p> <p>C. All staff will be educated on the importance of entering work orders for environmental and physical plant concerns in a timely manner. Staff will be re-educated on the process of entering work orders through the facility electronic system. Education will be provided by the Staff Development educator.</p> <p>D. A sampling of 4 rooms on each nursing wing and 1 common area will be audited weekly for cleanliness, furniture</p> | 5/26/16 |

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| F 253 | Continued From page 6 Wing B Room 12 - The walls by the bathroom door were scraped; - The front door was scraped; Wing B Room 16 - The A/C unit was held up by tape; - The dresser was very worn at the drawers; Wing B Room 17 - The A/C unit is held up by tape; Wing B Room 24 - The dresser was worn and edges were chipped; - The A/C vent was dirty; - The wall leading to the bathroom had loose floor molding; - The Sink was slow draining; Wing B Room 25 - Observed a hole in the wall next to B bed; - The drywall was cracked on the same wall next to the hole; - The night stand next to B bed had a chipped corner on the right side; - The second drawer on the night stand next to A bed had a missing handle; - The A/C unit was dirty; - The bathroom call light cover was cracked; - The bathroom sink was not draining properly; - The bathroom sink stopper was removed and sitting on the soap dish; - The bedroom walls were scratched around the bottom perimeter; - The floors were dirty; - The front door was chipped towards the bottom; - The wall by the right side of the bedroom window was chipped; - The dresser, night stand, TV stand were in | F 253 | condition, paint condition, a/c unit condition, bathroom fixture condition, and call light cover condition. The audit will be completed by the Maintenance Director or designee. This audit will continue weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations. | 5/26/16 | |

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| F 253 | Continued From page 7 disrepair with unfinished wood exposed. | F 253 | | | |
| F 278 SS=D | Findings were reviewed with E4 on 3/28/16 between 9:45 AM and 11:00 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/31/16 at approximately 2:15 PM. 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 | F 278 | | | |

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| F 278 | <p>Continued From page 8 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that the facility failed to accurately assess one (R72) out of 32 Stage 2 sampled residents. The facility failed to accurately assess R72 in the area of continence status. Findings Include:</p> <p>Review of CNA electronic documentation from 3/8/16 through 3/14/16 revealed that on 3/14/16 at 9:41 AM R72 was continent of bladder.</p> <p>The 3/14/16 quarterly MDS assessment stated R72 was "frequently incontinent" of bladder.</p> <p>On 3/24/16 at 3:00 PM during an interview, E5 (RNAC) stated she was the one that completed R72's 3/14/16 MDS assessment. However, upon review of the CNA documentation, E5 stated that the 3/14/16 entry for bladder continence was likely a data entry error.</p> <p>On 3/28/16 at 2:00 PM, E8 (CNA), who had documented R72 was continent of bladder on 3/14/16, was interviewed. E8 stated she knows R72 and that he never uses a urinal or the toilet, never asks to be toileted, and is unaware of when he needs to urinate. When asked about her documentation of his being continent on 3/14/16, E8 stated she remembered one morning when she checked his brief and it was dry, so she documented he was continent. It was explained to her that the correct entry should have stated that he did not void.</p> | F 278 | <p>R72</p> <p>A. The MDS was modified to reflect correct coding during survey and modified MDS was submitted to the state and accepted.</p> <p>B. RNAC / LNAC will interview Staff when CNA documentation appears inaccurate to ensure documentation is accurate. As MDS assessments are completed, the previous MDS will be reviewed for accuracy.</p> <p>C. All CNA's will be re-inserviced regarding incontinence coding in the POC by Staff Deveopment and will be done on an ongoing basis. As MDS's are completed, the MDS coordinator will audit involved residents medical record to ensure coding reflects current resident condition. involved CNA will be re-inserviced on the spot as errors are noted with each assessment by the RNAC/LNAC. Performance will be monitored by audits as stated in # D.</p> <p>D. Audits on incontinence coding in the MDS will be done dally until 100% compliance is met X 3 weeks, it then will be monitored for Compliance 3 X week for 3 weeks. Then monitored once a month for 100% compliance. The QAPI committee will determine the need for further audits and action plan.</p> | 5/26/16 |
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| F 278 | Continued From page 9 On 3/28/16 at approximately 2:30 PM, E5 was again interviewed and findings from the interview with E8 were reviewed. E5 confirmed that the MDS coordinator should have spoken with E8 and that the 3/14/16 MDS assessment was inaccurate. The facility failed to accurately assess R72 in the area of continence status. | F 278 | | | |
| F 279 SS=D | Findings were reviewed with E2 (DON) on 3/30/16 at approximately 4:30 PM. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced | F 279 | A.R 41 deficit act was not able to be Corrected with a voiding diary and care plan as R 41 was discharged. B. The RNAC will report list of CAA's to the Unit Managers on each unit to review all residents that triggered for care plans and ensure a care plan is developed and initiated. C. The Rnac will meet with the unit managers after each resident admission assessment, annual assessments and significant change to ensure the individualized plan of care has been established and the CAA's reviewed. All unit mangers, RNAC and LNAC will be educated on this process for CAA's/ Care plan communication by the ADON once and as needed.The ADON inserved on the Care Area Assessment (CAA) which includes after the annual, | By 5/26/2016 | |

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| F 279 | <p>Continued From page 10</p> <p>by: Based on record review and interview, it was determined that the facility failed to develop a comprehensive care plan for each resident with identified needs based on the comprehensive assessment for two (R41 and R68) out of 32 Stage 2 sampled residents with regard to urinary incontinence. Findings include:</p> <p>The facility's policy entitled, "Care Plan: Implementation and Review", dated 8/2015, stated, "Purpose: To provide guidelines to develop, review, and maintain a current, individualized Interdisciplinary Care Plan for each resident... A Care Plan will be completed within 7 days of completing the comprehensive assessment (MDS)... All Care Plans will be completed, customized (personalized), reviewed and evaluated by the interdisciplinary team prior to or at the Care Plan meeting, no later than day 21 after admission and then every quarter thereafter...".</p> <p>1. The admission MDS assessment, dated 12/18/15, stated R68 had short and long term memory problems and had moderate cognitive impairment. Additionally, R68 required limited assistance of one person for toileting, was not on a trial urinary toileting program and was occasionally incontinent of urine.</p> <p>The CAA associated with the 12/18/15 admission MDS triggered for urinary incontinence as a potential problem area and stated to proceed with care planning.</p> <p>Review of R68's care plans revealed there was no care plan developed for urinary incontinence although the CAA triggered. Additionally, the ADL</p> | F 279 | <p><i>C. continued</i></p> <p>significant change and admission MDS. The RNAC will review the CAA's that were triggered. If the RNAC says a care plan is needed they will ensure the care plan is in place. The RNAC was also educated to review all triggered items with the unit manager. The audits will be monitored to ensure elements addressed in the training were implemented accurately and consistently.</p> <p>D. The Care area assessment audit will be done by the RNAC/LNAC prior to the transmission of the MDS each time done daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100% then biweekly until 3 consecutive evaluations reach 100% then monthly ongoing to ensure compliance. The RNAC will audit all triggered items after an annual, significant change and admission to ensure an individualized care plan is established. All results will be brought to the facility QAPI meeting for further evaluations and recommendations.</p> | 5/26/16 | |

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| F 279 | <p>Continued From page 11</p> <p>deficit care plan, initiated 12/22/15, stated R68 required minimal assistance for toilet use and had no individualized approaches regarding incontinence.</p> <p>On 3/30/16 at 4 PM, in an interview, E7 (LPN UM) confirmed that a care plan was not developed for urinary incontinence although the CAA was triggered and the care plan decision was "yes" on R68's admission MDS.</p> <p>The facility failed to develop an individualized urinary incontinence care plan for R68. During an interview, on 3/31/16 at 10:40 AM, E2 (DON) and E3 (ADON) confirmed the findings.</p> <p>2. Cross refer to F315 example 1. Review of R41's clinical record revealed that the facility failed to develop an individualized care plan for R41 for an identified need of urinary incontinence.</p> <p>10/21/15 Admission MDS assessment indicated that R41 did not ambulate, needed extensive staff assistance for activities of daily living including bed mobility, transfers and toilet use. R41 was identified as occasionally incontinent of bladder during the seven (7) day review time period (10/15/15 - 10/21/15).</p> <p>10/21/15 CAA Summary indicated that R41's Urinary Incontinence needed to be addressed in the care plan. The triggering condition included: ADL needed extensive assistance for toileting; R41 was occasionally incontinent of bladder. However, R41's clinical record failed to show that a care plan for Urinary Incontinence was developed.</p> | F 279 | <p>A. Developed and initiated a voiding diary to create an individualized Plan of Care for incontinence for R 68. on 3/29/16</p> <p>B. The RNAC will report list of CAA's to the Unit Managers on each unit to review all residents that triggered for care plans and ensure a care plan is developed and initiated.</p> <p>C. The Rnac will meet with the unit managers after each resident admission assessment, annual assessments and significant change to ensure the individualized plan of care has been established and the CAA's reviewed. All unit mangers, RNAC and LNAC will be educated on this process for CAA's/ Care plan communication by the ADON once and as needed. The ADON inserviced on the Care Area Assessment (CAA) which includes after the annual, significant change and admission MDS. The RNAC will review the CAA's that were triggered. If the RNAC says a care plan is needed they will ensure the care plan is in place. The RNAC was also educated to review all triggered items with the unit manager. The audits will be monitored to ensure elements addressed in the training were implemented accurately and consistently.</p> | By 5/26/2016 | |

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| F 279 | Continued From page 12 The facility failed to ensure that R41 had a care plan to address Urinary Incontinence based on the 10/21/15 admission MDS assessment. This finding was reviewed with E2 on 3/30/15 at approximately 9:30 AM and on 3/31/15 at approximately 2:00 PM. | F 279 | continued from page 12 D. The Care area assessment audit will be done by the RNAC/LNAC prior to the transmission of the MDS each time done daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100% then biweekly until 3 consecutive evaluations reach 100% then monthly ongoing to ensure compliance. The RNAC will audit all triggered items after an annual, significant change and admission to ensure an individualized care plan is established. All results will be brought to the facility QAPI meeting for further evaluations and recommendations. | 5/20/16 |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of other facility documentation, it was determined that the facility failed to ensure that 2 (R41 and R68) out of 32 Stage 2 sampled residents, who were incontinent of bladder, received appropriate care and services to restore as much bladder function as possible and to prevent infections. The facility failed to comprehensively assess R41 and R68's urinary incontinence, failed to complete voiding diaries and failed to individualize their toileting plans, that resulted in the decline of their urinary continence. Findings include: | F 315 | | |

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| F 315 | <p>Continued From page 13</p> <p>The facility's policy entitled, "...Bladder Retraining Program" to help incontinent residents regain their ability to control bladder function, stated, "...Information must be collected concerning the resident's present and pre-incontinent...bladder pattern...Assess resident with tool for 3 days (voiding diary). Encourage the resident to toilet at the same time daily...If a resident is not able to demonstrate dry pattern or follow instructions establish a toileting program...If a resident is able to stay dry and establish toileting times based on assessment, assess program continually, modifying times until resident is at max (maximum) number of hours between toileting. This is the final pattern. Put on Care Plan and reassess if resident has incontinence episodes. Times for scheduled toileting must be specified in the resident's care plan".</p> <p>1. Review of R41's clinical record revealed the following; R41 was admitted to the facility on 10/15/15 from home with diagnoses including Dementia, Urge incontinence, Nocturia and Generalized Muscle weakness. 10/15/15 Admitting Progress Note stated that R41 was admitted due to a declining cognition, recent decline in mobility and history of falling and currently not ambulatory, spending most of her time in a wheelchair. R41 was able to stand to transfer with contact guard, can take a few steps, but knees are weak.</p> <p>10/15/15 The facility scheduled a toileting program for R41 that stated, to toilet daily while awake every 2-4 hours, that is, at 12:00 AM, 6:00 AM, 10:00 AM, 4:00 PM, 8:00 PM and 10:00 PM. 10/16/15-R41 was started on a water pill, Lasix,</p> | F 315 | <p>C (cont) from pg 13</p> <p>voiding diary on each resident 3 days after admission. Education on the policy and procedure for the bowel and bladder program will be in-served by the staff Developer. The staff developer will in-service on the 3 day voiding diary, incontinence coding on the POC and the diagnosis associated with Incontinence. The ADON will in-service all Unit managers on the evaluation of the voiding diary to establish an individualized toileting schedule and Care Plan. ADON in-serviced the RNAC and LNAC on incontinence coding and accuracy and review CAAs with Unit managers. The audits will be monitored to ensure elements addressed in the training were implemented accurately and consistently.</p> <p>(cont pg 15)</p> | 5/26/16 | |

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| F 315 | <p>Continued From page 14</p> <p>daily per physician's order and a 3 day voiding diary was initiated.</p> <p>On 10/16/15, the facility also identified in a care plan that R41 has a potential for falls and injury related to her poor safety awareness and history of falls, and needed to be encouraged to call for assistance for transfers and toileting needs.</p> <p>10/17/15, (second day of the voiding diary), facility staff failed to complete the voiding assessment on the 11-7 AM and 7-3 PM shift.</p> <p>10/18/15, (3rd day of the voiding diary), facility staff failed to complete the assessment of the 7-3 PM shift. The facility failed to establish an accurate and final pattern of R41's voiding based on the incomplete 3 day voiding diary. Instead, the facility continued to use the toileting schedule of every 2-4 hours as documented in the CNAs' Intervention and Tasks for 10/2015 through 2/2016.</p> <p>10/21/15 Admission MDS assessment indicated the following: R41's BIMS score was 15, cognitively intact. R41 did not ambulate, needed extensive assistance (weigh bearing support) of one staff member with transfer and toilet use. R41 was identified as occasionally incontinent of bladder during the seven (7) day review period.</p> <p>10/21/15 The CAA indicated that R41's Urinary Incontinence needed to be addressed in the care plan. The triggering condition included: R41 was occasionally incontinent of bladder and ADL assistance for toileting was needed as indicated by extensive assistance. No care plan was developed for the problem on Urinary Incontinence.</p> | F 315 | <p>(cont from pg 14)</p> <p>D. The Incontinence audit will be done by the unit manager or designee daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then bi-weekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. The audits will consist of monitoring the bowel and bladder assessments, review of the voiding diary, implementation of an individualized toileting schedule and accuracy of the MDS coding. All results will be brought to the facility QAPI meeting for further evaluations and recommendations.</p> | 5/26/16 | |

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| F 315 | <p>Continued From page 15</p> <p>Review of R41's record also revealed that R41 fell (unwitnessed) on 10/28/15 in the bathroom when she tried to stand up. She did not sustain any injury.</p> <p>10/29/15 R41 had another unwitnessed fall trying to get up to go to the bathroom and bumped her head. R41 sustained a raised swollen area with discoloration of her right temple that measured .5 x 1.5 x 0.8 cm that required neuro checks and observation at the nurse's station.</p> <p>In addition, on 10/29/15, the physician ordered to have a UA and C&S be done due to R41's symptoms of increased confusion.</p> <p>11/1/15, R41's urine tests showed positive for UTI (colony count of >100, 000 CFU/ml, [colony forming units per milliliter] positive for Strep Viridan organisms) and she was ordered to take the antibiotic medication Doxycycline twice a day.</p> <p>11/1/15, R41 continued to be confused and had urinary urgency.</p> <p>There was no voiding diary initiated based on the result of R41's admission MDS assessment dated 10/21/15 and current condition (UTI).</p> <p>11/3/15, 3:55 PM IDT note by E17 (LPN) indicated that the facility initiated the same ineffective every 2-4 hours toileting schedule, that is, 12:00 AM, 6:00 AM, 10:00AM, 1:00 PM, 4:00 PM, 8:00 PM and 10:00 PM which was previously in place and again without knowing R41's voiding pattern.</p> <p>11/5/15, 10:41 PM E16 (RN) wrote that R41 no longer had urinary urgency and frequency as before the start of treatment.</p> | F 315 | <p>A. R 68 a voiding diary x 3 days was initiated to develop an individualized toileting program plan of care as assessed.</p> <p>B. All resident's triggered for Urinary incontinence in the MDS were reviewed to ensure that an individualized care plan was developed.</p> <p>C. The RNAC or designee will monitor the 7-day look back when doing the MDS for the urinary incontinence pattern for accuracy on each resident as each MDS is done. The unit managers or designee will review and audit all steps of the bowel and bladder program to ensure it is followed per policy and protocol. Unit managers are monitoring the completion of the voiding diary on each resident 3 days after admission. Education on the policy and procedure for the bowel and bladder program will be in-served by the staff Developer. The staff developer will in-service on the 3 day voiding diary, Incontinency coding on the POC and the diagnosis associated with incontinence.</p> | by 5/26/16 | |

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| F 315 | <p>Continued From page 16</p> <p>1/5/16 R41 Facility's Bladder and Bowel Program Screening stated that R41's continent episode was less than weekly.</p> <p>1/7/15 -Quarterly MDS assessment stated that R41's urinary continence condition declined from occasionally incontinent to frequently incontinent.</p> <p>The facility failed to ensure that R41, who was incontinent of bladder, had an established and individualized toileting schedule based on a 3 day voiding diary assessment of R41's voiding pattern and specified in R41's care plan, to restore as much normal bladder function as possible.</p> <p>Findings were reviewed with E2 (DON) on 3/30/15 at approximately 9:40 AM.</p> <p>2. Review of R68's clinical record revealed the following;</p> <p>R68 was admitted to the facility on 12/12/15 with diagnoses including dementia and psychosis.</p> <p>The admission nursing assessment, dated 12/12/15, stated R68 was continent of urine.</p> <p>The Bladder and Bowel Program screening (assessment/evaluation), dated 12/13/15, stated R68's bladder continence was usually continent, may be a candidate for a retraining program. This assessment was completed within 24 hours of R68's admission.</p> <p>Per the EMR, completed by CNAs, R68 was incontinent of urine on 12/14/15 at 2:59 PM and at 10:59 PM, however, the facility did not capture R68's urinary incontinence due to the bladder</p> | F 315 | <p>C. (Cont from pg 16)</p> <p>The ADON will in-service all Unit managers on the evaluation of the voiding diary to establish an individualized toileting schedule and Care Plan. ADON in-serviced the RNAC and LNAC on incontinence coding and accuracy and review CAAs with Unit managers. The audits will be monitored to ensure elements addressed in the training were implemented accurately and consistently.</p> <p>D. The Incontinence audit will be done by the unit manager or designee daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then bi-weekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. The audits will consist of monitoring the bowel and bladder assessments, review of the voiding diary,</p> <p>(Cont on pg. 18)</p> | by 5/26/16 |
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| F 315 | <p>Continued From page 17 program screening being completed on 12/13/15.</p> <p>R68's record, both hard copy and EMR, were reviewed and lacked any evidence that a 3 day Bowel and Bladder Pattern Record was completed.</p> <p>The admission MDS, dated 12/18/15, stated R68 had short and long term memory problems with moderate cognitive impairment, required limited assistance of one person for toilet use, was not on a trial urinary toileting program and was occasionally incontinent of urine.</p> <p>R68's CAA, associated with the 12/18/15 admission MDS, triggered for urinary incontinence as a potential problem area and stated to proceed with care planning, however, no individualized urinary incontinence care plan was developed.</p> <p>Per the EMR, completed by CNAs, R68 was incontinent of urine 17 times during the month of December 2015 with only one occurrence on dayshift.</p> <p>Per the EMR, completed by CNAs, R68 was incontinent of urine on 1/1/16 at 6:59 AM, on 1/2/16 at 6:59 AM and 10:59 PM, on 1/3/16 at 10:59 PM, on 1/5/16 at 10:59 PM and 1/6/16 at 10:59 PM.</p> <p>The Bladder and Bowel Program screening, dated 1/7/16, incorrectly assessed R68's bladder continence as usually continent with incontinence once a week or less, may be a candidate for a retraining program. Review of R68's record, again, lacked any evidence of a 3 day Bowel and Bladder Pattern Record being completed.</p> | F 315 | <p><i>D. (cont from pg 17)</i></p> <p>implementation of an individualized toileting schedule and accuracy of the MDS coding. All results will be brought to the facility QAPI meeting for further evaluations and recommendations.</p> | |

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| F 315 | <p>Continued From page 18</p> <p>Per the EMR, completed by CNAs, R68 was incontinent of urine as follows: On 3/3/16 at 2:26 AM, 2:27 AM, 10:37 PM, 10:39 PM, 10:42 PM, 10:43 PM, 10:44 PM; On 3/4/16 at 2:31 PM, 4 times at 10:05 PM; on 3/5/16 at 3:07 AM, 3 times at 9:54 PM and 2 times at 9:56 PM; on 3/6/16 at 10:29 PM, 10:30 PM, 10:31, PM and 2 times at 10:32 PM; on 3/7/16 at 1:38 AM, 4:27 AM, 10:24 AM, 2:05 PM, 9:34 PM and 9:35 PM; on 3/8/16 at 2 times at 10:23 PM, at 10:24 PM and 2 times at 10:25 PM; on 3/9/16 at 3:57 AM, 3 times at 9:40 PM and 2 times at 9:42 PM.</p> <p>The quarterly MDS, dated 3/9/16, stated R68 had severe cognitive impairment, required limited assistance of one person for toilet use, was not on a trial urinary toileting program and was frequently incontinent of urine.</p> <p>The Bladder and Bowel Program screening, dated 3/9/16, incorrectly assessed R68's bladder continence as usually continent with incontinence once a week or less, may be a candidate for a retraining program. Review of R68's record, again, lacked any evidence of a 3 day Bowel and Bladder Pattern Record being completed.</p> <p>On 3/30/16 at 12:20 PM, R68 was observed walking out of her room into the hallway. R68 spoke with E7 (LPN UM) and stated she had emptied her ileostomy bag. E7 asked R68 if she had voided and R68 responded, "no".</p> <p>In an interview, on 3/30/16 at 3:19 PM, E20 (CNA) stated she was assigned on nightshift to the resident, R68, in the past week and the resident's pull up/incontinent brief was wet a few times so she recorded it on the EMR as</p> | F 315 | | | |

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| F 315 | <p>Continued From page 19</p> <p>incontinent. E20 stated that the resident will go to the bathroom but will sometimes wet the pull up before voiding. However, review of the urinary continence/incontinence report from R68's EMR, revealed that E20 recorded R68 was continent 5 times on 3/28/16 nightshift.</p> <p>In an interview, on 3/30/16 at 4:04 PM, E24 (LPN) was asked about how she completed the Bladder and Bowel Program screening for R68? E24 stated that she based it upon changing R68's ileostomy bag during the week and checking her pull up at that time which was dry. When asked about R68's urinary continence/incontinence, E24 stated she was not aware that she could review the CNA documentation in the EMR pertaining to R68's continence status.</p> <p>In an interview, on 3/30/16 at 4:17 PM, E21 (CNA) stated R68 was continent during evening shift and that the resident knew when she had to go to the bathroom. E21 stated she accompanied the resident to the bathroom and R68's pull up was dry. E21 stated that she worked when E23 (CNA) was off so she cared for R68 regularly.</p> <p>In an interview, on 3/31/16 at 8:09 AM, E19 (CNA) stated R68's pull up was dry when she got up this morning. E19 stated, "The resident is always dry for me".</p> <p>On 3/31/16 at 8:40 AM, R68 was observed walking in the hallway and was approached by E7 who asked the resident did she want to use the bathroom? R68 stated, "no".</p> <p>On 3/31/16 at 10:40 AM, in an interview with E2 and E3 (ADON), E3 stated that no 3 day bladder patterns/voiding diaries were done</p> | F 315 | | |

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| F 315 | Continued From page 20 because R68 was considered continent of urine. After reviewing the urinary continence/incontinence reports from admission on 12/12/15 through 3/31/16 at 8 AM, E2 stated that she did not know why E21 documented that R68 was continent of urine during evening shift while E23 documented R68 was incontinent. E2 stated she did not know if the documentation was accurate or if there were issues as to what continence and incontinence meant. With regard to urinary incontinence for R68, the facility failed to: - Complete 3 day Bowel and Bladder Pattern Records; - Accurately assess the resident on the Bladder and Bowel Program screenings, dated 1/7/16 and 3/9/16; - Accurately record urinary continence/incontinence in the EMR; - Identify R68's decline in urinary continence from occasionally incontinent on the admission MDS, dated 12/18/15, to frequently incontinent on the quarterly MDS, dated 3/9/16; - Develop an individualized approach/plan of care to address the urinary incontinence in an attempt to restore as much normal bladder function as possible. | F 315 | | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to | F 323 | | | |

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| F 323 | Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/22/16 and 3/23/16 during Stage 1 and during the environmental tour with E4 (FMD) on 3/28/16 between 9:45 AM and 11:00 AM, it was determined that the facility failed to ensure three residents (R44, R87, and R146) out of 40 sampled Stage 2 residents remained free from accident hazards as much as possible and received adequate supervision and assistive devices to prevent accidents. Furthermore, the facility failed to keep residents rooms free of accident hazards for 4 rooms (Wing B 3A, 25A, and Wing A 16C, 31A) out of 36 rooms. Findings Include: 1. Review of the lift and transfer quarterly assessment dated 1/11/16 stated R44 had moderate upper body strength and the ability to hold onto the bar. Review of the annual MDS dated on 3/16/16 stated R44 could safely perform greater or equal to 50% of lift or transfer with only limited assistance. An observation made during stage 1 of R44's bedroom on 3/23/16 at 10:14 AM revealed that the bilateral quarter rails on the resident's bed were loose. Finding was reviewed and confirmed with E4 on | F 323 | F 323 Facility failed to provide a hazard free environment to prevent accidents for 3 residents and 4 rooms. A. Deficient practices for the following residents were corrected. R-44 quarter rails tightened. B. All residents utilizing quarter rails and halo bars will be audited for secure fastening. This is to ensure that no other resident is affected by this deficient practice. This will be completed by the Maintenance Director/designee. All findings will be reported to the NHA and promptly corrected. C. All staff will be educated on the importance of entering work orders for unsecure quarter rails & halo bars upon discovery. All staff will be re-educated on the process of entering work orders through the facility electronic system. Education will be provided by the Staff Development educator/Designee. D. A sampling of 4 rooms on each nursing wing will be audited weekly for | 5/26/16 |
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| F 323 | <p>Continued From page 22 3/28/16 at 10:10 AM during the environmental tour.</p> <p>2. Review of the facility's quarterly lift and transfer assessment dated 3/1/16 stated R87 had the upper body strength and ability to hold onto the bars.</p> <p>Review of the annual MDS dated on 3/7/16 stated R87 required limited assistance for bed mobility and transfer</p> <p>An observation made during stage 1 of R87's bedroom on 3/23/16 at 8:51 AM revealed that the bilateral quarter rails on the resident's bed were loose.</p> <p>Finding was reviewed and confirmed with E 4 on 3/28/16 at 10:50 AM during the environmental tour.</p> <p>3. The following observations were made on 3/22/16 and 3/23/16 during Stage 1 review and during the environmental tour on 3/28/16 between 9:45 AM and 11:00 AM.</p> <p>Wing A Room 16 - The bathroom had uncovered toilet bolts with long screws sticking up;</p> <p>Wing A Room 31 - The bathroom had uncovered toilet bolts with long screws sticking up;</p> <p>Wing B Room 3 - The toilet seat was loose;</p> | F 323 | <p>quarter rail/ halo security. The audit will be completed by the Maintenance Director or designee. This audit will continue weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations.</p> <p>A. Deficient practice for the following resident was corrected. R87 quarter rail tightened.</p> <p>B. All residents utilizing quarter rails and halo bars will be audited for secure fastening. This is to ensure that no other resident is affected by this deficient practice. This will be completed by the Maintenance Director/designee. All findings will be reported to the NHA and promptly corrected.</p> <p>C. All staff will be educated on the importance of entering work orders for unsecure quarter rails &, halo bars upon discovery.</p> | 5/26/16 | |

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| F 323 | <p>Continued From page 23</p> <p>Wing B Room 25 - The bathroom had uncovered toilet bolts with long screws sticking up.</p> <p>Findings were reviewed and confirmed with E4 on 3/28/16 between 9:45 AM and 11:00 AM during the environmental tour.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/31/16 at approximately 2:15 PM.</p> <p>4. R146 was admitted to the facility 9/21/15 with diagnoses that included CVA, hemiplegia and obesity. R146 weighed 249 lbs.</p> <p>9/21/15 the facility initiated a care plan entitled, "Potential for falls related to weakness" with interventions that included, "unable to do own ADL's without assistance secondary to CVA", "educate resident and family on safety measures and importance of their use" and "assist rails (a halo bar/ circular siderail with vertical mounting bar attached to both sides of the upper bed)" to aid in bed mobility.</p> <p>According to R146's admission MDS assessment, dated 9/28/15, this resident needed extensive assistance of 2 staff members for bed mobility, total dependence on 2 staff members for transfers between surfaces such as bed to chair, wheelchair and back to bed. R146 did not ambulate and used a wheelchair for mobility around the unit.</p> <p>On 3/22/16 at approximately 11:46 AM, during the Stage 1 of the survey, the surveyor observed that</p> | F 323 | <p>All staff will be re-educated on the process of entering work orders through the facility electronic system. Education will be provided by the Staff Development educator/Designee.</p> <p>D. A sampling of 4 rooms on each nursing wing will be audited weekly for quarter rail/ halo security. The audit will be completed by the Maintenance Director or designee. This audit will continue weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations.</p> <p>A. Deficient practice for the following resident was corrected. R-146 halo bars were securely fastened.</p> <p>B. All residents utilizing quarter rails and halo bars will be audited for secure fastening. This is to ensure that no other resident is affected by this deficient practice. This will be completed by the</p> | 5/26/16 |

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| F 323 | Continued From page 24 the halo bars [circular ring of the slide rail bar] to aid R146 to move and turn in bed, was not secure. The fit was loose and could be turned from side to side from the vertical mounting bar. On 3/28/16 at approximately 8:45 AM it was observed by surveyor that the halo bar remained loose. E4 (FMD) was notified immediately on 3/28/15 at approximately 9:30 AM and findings were confirmed by hlm. | F 323 | Maintenance Director/designee. All findings will be reported to the NHA and promptly corrected. C. All staff will be educated on the importance of entering work orders for unsecure quarter rails & halo bars upon discovery. All staff will be re-educated on the process of entering work orders through the facility electronic system. Education will be provided by the Staff Development educator/Designee. | |
| F 371 SS=E | 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: | F 371 | D. A sampling of 4 rooms on each nursing wing will be audited weekly for quarter rail/ halo security. The audit will be completed by the Maintenance Director or designee. This audit will continue weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations. | 5/26/16 |

F323 continued

- A. Deficient practices for the following rooms were corrected. A-16, A-31, B-25 toilet bolts have been covered. B-3 toilet seat has been secured.
- B. All resident toilet seats will be audited for secured fastening. All resident toilet bolts will be audited for the presence of toilet bolt covers. This is to ensure that no other resident is affected by this deficient practice. This will be completed by the Maintenance Director/designee. All findings will be reported to the NHA and promptly corrected.
- C. All staff will be educated on the importance of entering work orders for missing toilet bolt covers and unsecure toilet seats upon discovery. All staff will be re-educated on the process of entering work orders through the facility electronic system. Education will be provided by the Staff Development educator/Designee.
- D. A sampling of 4 rooms on each nursing wing will be audited weekly for missing toilet bolt covers and unsecure toilet seats. The audit will be completed by the Maintenance Director or designee. This audit will continue weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure

compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations.

Complete by
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| F 371 | <p>Continued From page 25</p> <p>1. The following were observed on 3/22/16 between 11:00 AM and 12:00 PM during the kitchen tour:</p> <ul style="list-style-type: none"> - Observed clean eating utensils stored food contact part facing up. Utensils with food surface facing up will increase the chance of cross contamination for users. - Observed clean kitchen service utensils drying above wax paper. Paper absorbs moisture and encourages microbial growth. - Observed three knives stored between the wall and 3-compartment sink next to the dish washer. Using improperly stored kitchen utensils will cause cross contamination during food preparation. <p>Findings were reviewed and confirmed by E10 (FSD) and E9 (AFSD) during the kitchen tour on 3/22/16 between 11:00 AM and 12:00 PM.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/31/16 at approximately 2:15 PM.</p> <p>2. On 3/23/16 from 12:50 PM through 1:10 PM, observations of the midday meal in the Hammond wing dining room revealed the following:</p> <ul style="list-style-type: none"> - E9 was observed touching the tops of steam table covers with his gloved hands, and then using the same (now contaminated) gloved hands to push out ground turkey from a bowl onto plates; - E9 ungloved; made a phone call then regloved (without washing hands), again touched tops of | F 371 | <p>F 371</p> <p>Facility failed to store, prepare, distribute and serve food under sanitary conditions.</p> <ul style="list-style-type: none"> A. Deficient practices were corrected upon discovery. Eating utensil storage immediately changed from utensil food surface facing up to food surface facing down in storage container B. No other deficient practices in storing utensils was found. C. All dining staff has been educated by the Dining Manager/designee on proper storage of utensils. D. Dining Manager/designee will audit utensil storage daily until 3 consecutive evaluations reach 100%, then weekly until 3 consecutive evaluations reach 100%, then bi monthly until 3 consecutive evaluations reach 100% compliance, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations. | 5/26/16 |

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| F 371 | Continued From page 26 steam table covers and then picked up bread sticks with the same, now contaminated, gloved hands; - at approximately 1:00 PM, E9 left the steam table area still wearing gloves and went to the side cabinet, looked into the cabinet after touching the handles and then went back to the steam table and resumed plating and touching bread sticks with the contaminated gloved hands; - at 1:07 PM, E9 was observed washing his hands briefly, turning off the faucets with his bare hands, recontaminating his clean hands and then reaching for paper towels to dry hands; - at approximately 1:10 PM, E9 washed his hands, got paper towels, dried his hands and used the paper towels to turn off the faucet. Instead of then discarding the paper towels, E9 used them to wipe water off the entire sink counter area, then re-wiped his hands with the soiled paper towels thus recontaminating his clean hands. Findings were confirmed by E9 during interview on 3/22/16 at approximately 1:20 PM. Findings were reviewed with E2 on 3/30/16 at approximately 4:30 PM. | F 371 | A. Deficient practices were correct upon discovery. Knife storage moved away from area of 3 compartment sink. B. No other deficient practices in storing knives was found. C. All dining staff has been educated by the Dining Manager/designee on proper storage of knives. D. Dining Manager/designee will audit knife storage daily until 3 consecutive evaluations reach 100%, then weekly until 3 consecutive evaluations reach 100%, then bi monthly until 3 consecutive evaluations reach 100% compliance, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations. | 5/26/16 |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug | F 431 | A. Deficient practices were correct upon discovery. Practice of drying utensils above wax paper was immediately discontinued. B. No other deficient practices in utensil drying was found. | 5/26/16 |

F371 Continued.

- C. All dining staff has been educated by the Dining Manager/designee on proper utensil drying procedures.
- D. Dining Manager/designee will audit utensil drying daily until 3 consecutive evaluations reach 100%, then weekly until 3 consecutive evaluations reach 100%, then bi monthly until 3 consecutive evaluations reach 100% compliance, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations.
- A. Deficient practices of improper food handling/glove usage was noted during surveyor dining observation. All Residents in dining area had the potential for impact.
- B. All residents are at risk for this deficient practice. No other deficient practices food handling related to glove usage and handwashing were noted during subsequent dining observations.
- C. All dining staff has been educated by the Dining Manager/designee on proper handwashing, food handling and glove usage/changing procedures.
- D. Dining Manager/designee will audit a sampling of 4 dining employees for proper glove usage, handwashing and food handling weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluation and recommendations.

Complete
by
5/26/16

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| F 431 | <p>Continued From page 27</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record reviews and staff interview, it was determined that the facility failed to ensure that a system of records (Narcotic Control Record) kept for the receipt and disposition of all controlled medications was conducted by two (2) licensed nurses at each shift. The lack of a signature to attest to the shift counts occurred on three (3) out of five (5) units</p> | F 431 | | | |

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| F 431 | <p>Continued From page 28 and six (6) out of ten (10) medication carts. Findings include:</p> <p>Review of the pharmacy manual policy entitled "Inventory Control of Controlled Substances", last revised 1/1/13, stated, "... 2. Facility should ensure that Facility staff count all Schedule III-V controlled substances in accordance with Facility policy and Applicable Law...".</p> <p>The facility's nursing policy entitled "Controlled Medications", last revised 8/2015, stated, "...6d. A count of all Controlled medications will be done at the end of each shift by the oncoming licensed nurse and off-going licensed nurse. The physical inventory count of each Controlled medication will be documented on the Narcotic Inventory Check List by the licensed nurses ...".</p> <p>Review of the facility's Narcotic Control Records for 6 out of 10 medication carts from January 1, 2016 through March 23, 2016 revealed the facility failed to ensure that all controlled medications were counted by two nurses, the off-going nurse and on-coming nurse, at the end of each shift as follows:</p> <p>1. Hammond Wing - medication cart 1: 22 out of 186 opportunities were missing signatures of either the on-coming nurse and/or the off-going nurse;</p> <p>2. Hammond Wing - medication cart 2: 61 out of 186 opportunities were missing signatures of either the on-coming nurse and/or off-going nurse;</p> <p>3. Hammond Wing - medication cart 3: 64 out of 186 opportunities were missing signatures of</p> | F 431 | <p>A. No resident affected. Unable to correct past Control Records remaining with absence of nurse signatures due to legalities of back dating and signing.</p> <p>B. Immediately initiated re-education to nurses the importance of documentation of signatures during change of the shift narcotic count and assigned the supervisors of each shift to observe nurses at the change of the shift documenting their signatures before going off duty; by the ADON and DON.</p> <p>C. The nurses and supervisors will be re-educated by the ADON and the DON on the importance of following the regulations and the required signature of the oncoming shift nurse and the off going shift nurse required at the time of the narcotic count before the nurse goes off duty at the end of shift and still in facility on daily basis ongoing at shift change. The observation of the required signatures by the supervisors of each shift will ensure 100% compliance meeting with the nurses at the time of shift change with the actual Narcotic Count at the medication cart daily. This same Training will be ongoing to any new hires nurses at the time of</p> | <p>5/26/16</p> <p>on 4/25/16</p> |

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

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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 03/31/2016 |
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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 431 | Continued From page 29 either the on-coming nurse and/or off-going nurse; 4. Christina Wing - lower end medication cart: 25 out of 186 opportunities were missing signatures of either the on-coming nurse and/or off-going nurse; 5. Christina Wing - upper end medication cart: 30 out of 186 opportunities were missing signatures of either the on-coming nurse and/or off-going nurse; 6. Ashland Wing - lower end medication cart: 25 out of 186 opportunities were missing signatures of either the on-coming nurse and/or off-going nurse. During an interview with E2 (DON) on 3/24/16 at 1:44 PM, findings were confirmed. | F 431 | F431 C. continued from previous pg. 29 orientation. The Narcotic Record Sheet will be monitored by the supervisor of each shift at the change of the shift while nurses are counting the narcotics and ensure the nurses at the change of shift have completed the record with their signature when Narcotics / Controls are counted. | By 5/26/16 |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. | F 441 | D. The Narcotic Control Records audit will be done by the ADON or designee daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluations and recommendations. | |

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| F 441 | Continued From page 30 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain an Infection Control Program designed to provide 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 utilize PPE when entering R166's room as required for Droplet Precaution isolation. The facility failed to ensure that staff followed accepted professional practices for the changing of disposable gloves when indicated and they failed to complete hand washing correctly. Findings include: The undated facility policy titled "Policy for | F 441 | F 441 A. R 166 No longer infectious; was treated with antibiotic therapy and is completed with no further isolation required. Unable to correct. Immediately reviewed Droplet Precautions with staff per Staff Developer. B. No other resident s affected; No new onsets of Infection evident. Will identify any resident with any isolation requirements and review details of Policy and Procedure on the droplets precautions in Infection control with all involved staff on the unit by the unit manager, ongoing, as indicated; to ensure communication and proper protocol is followed for droplet precautions. A sign is also on the door frame of the involved resident with a color code indicating the type of precautions. Cont. on pg. 32 | 5/26/16 |

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| F 441 | <p>Continued From page 31</p> <p>Isolation" stated, "...Transmission-Based Precautions will be employed for known or suspected infections for which the route of transmission is known. The Transmission-Based categories are:...Droplet, Contact..."</p> <p>The undated facility policy titled "Procedure for Isolation: Initiation of Isolation" stated, "...B. Transmission-Based Precautions...2. Droplet Precautions:...use Droplet Precautions for a resident known or suspected to be infected with microorganisms transmitted by droplets...that can be generated by the resident sneezing, coughing, talking, etc., and drop from the air after a distance of 3 feet...3. Contact Precautions:...for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items...The above includes...organisms such as MRSA..."</p> <p>The undated facility procedure for "Droplet Precautions" stated, "... (Potential exposure to microorganisms through droplets, via cough, sneeze, etc.) Place resident in a private room if possible...Door may remain open. Maintain a minimum of 3 feet between the infected resident and others. Wear a mask or face shield if you come within 3 feet of the resident..."</p> <p>The undated facility procedure for "Contact Precautions" stated, "(Potential exposure to microorganisms through direct contact with the resident, or indirect contact with their belongings) Private room is desirable...Door may remain open. Wear gloves when entering the room...Wash hands after every resident contact. Wear a gown if you anticipate that your clothing</p> | F 441 | <p>Cont. from pg 31</p> <p>C. All residents will be monitored Daily for any onset of Respiratory Infections, identify If Droplet Precautions are required. This is logged on a weekly basis by the Staff Developer on the Infection Control spread Sheet Log. Any trends identified will be reviewed. Random observations of staff and their adherence to droplet precautions compliance on all identified residents will be ongoing, by Staff Developer. All staff will be In-serviced on Droplet Precautions and the Infection control Policy and Procedure by the Staff Developer. And all new hire Staff at the time of Orientation.</p> <p>Cont. on pg. 33</p> | By 5/26/16 |

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| F 441 | <p>Continued From page 32 may become contaminated..."</p> <p>Review of the facility's Infection Control Manual for Long-Term Care Facilities, Section E page E11, stated that for respiratory multidrug-resistant organisms (e.g., MRSA) Droplet and Contact Precautions were required.</p> <p>1. Review of R166's clinical record revealed this resident was on Droplet Precautions for MRSA in the sputum starting on 3/11/16.</p> <p>The following observations were made of facility staff failing to utilize PPE when entering R166's room:</p> <ul style="list-style-type: none"> - 3/22/16 at 12:22 PM - E11 (CNA) entered R166's room without applying any PPE and placed the meal tray on the over-bed table in front of R166, who was sitting in a chair. E11 then exited the room and returned to passing out meal trays to other residents in the same hallway without first washing her hands. - 3/28/16 at 8:42 AM - E12 (LPN) in R166's room speaking to resident and not wearing any PPE. - 3/28/16 at 8:55 AM - E13 (CNA) dropped off R166's breakfast tray into the room, placing it on the over-bed table without wearing any PPE. Although R166 was in the bathroom at the time, the potential for E13 touching a contaminated surface was present. - 3/29/16 at 12:10 PM - E11 entered R166's room to deliver the meal tray wearing a gown and gloves, but no mask. E11 placed the tray on the over-bed table in front of where R166 was seated. | F 441 | <p>Cont. from pg. 32</p> <p>D. The Infection control audit will be done by the ADON or designee daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance.</p> <p>All results will be brought to the facility QAPI meeting for further evaluations and recommendations.</p> | 5/26/16 |

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| F 441 | <p>Continued From page 33</p> <p>- 3/29/16 at 1:55 PM - E14 (housekeeping staff) observed in R166's room cleaning and emptying trash while the resident was seated at the bedside. E14 was wearing gloves, but not wearing a gown or mask.</p> <p>The facility failed to ensure staff wore appropriate PPE when entering R166's room.</p> <p>On 3/29/16 at 2:47 PM, findings were reviewed with E18 (Infection Control Nurse).</p> <p>On 3/30/16 at approximately 4:30 PM findings were reviewed with E2 (DON).</p> <p>2. On 3/28/16, E22 (Activity Aide) was observed incorrectly washing/drying his hands on two (2) occasions as follows:</p> <p>- 1:00 PM - E22 was observed washing his hands, he then took paper towels and turned off the faucet with the paper towels. Instead of discarding the now contaminated towels, he used them to dry his hands.</p> <p>- 1:34 PM - E22 was again observed washing his hands. He again used paper towels to turn off the faucet and then used the contaminated towels to dry his hands.</p> <p>Findings were confirmed with E22 immediately after the observation.</p> <p>3. On 3/30/16 at 8:35 AM during the medication pass observation in the Hammond wing E15 (RN) used gloves to clean R153's eye shield that was on floor and then continued to do a blood sugar stick on R153 using the same contaminated gloves. Findings were reviewed and confirmed with E15 on 3/30/16 at 11:25 AM.</p> | F 441 | <p>2.) A. Deficient Act of Hand washing by staff member. Staff member involved was immediately spoke to on proper hand washing by Staff Developer.</p> <p>B. Initiated in-service on the Policy and Procedure for Hand washing per CM guidelines.</p> <p>C. The Policy and Procedure on Hand washing will be In-serviced to all staff and all new hires by the Staff Developer including return hand washing demonstrations. Random hand washing competencies of staff adherence, ongoing, by Staff Development.</p> <p>(cont pg 35)</p> | <p>Training Initials 4/28/16</p> <p>By 5/26/16</p> |

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| 41 | Continued From page 34 Findings were reviewed with E1 (NHA) and E2 during the exit conference on 3/31/16 at approximately 2:15 PM. | F 441 | 2.) cont from page 34). D. Hand washing competencies will be done by the ADON or designee daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluations and recommendations. | By 5/26/2016 |

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F441 Continued From page 34
 Findings were reviewed with E1 (NHA) and E2 during the exit conference on 3/31/16 at approximately 2:15 PM.

F 441

3.) A. Deficient Act of failure to change gloves by staff member. Staff member involved was immediately spoke to on proper protocol for changing gloves by Staff Developer.

B. Initiated in-service on the Policy and Procedure for Contact Precautions and changing of gloves with staff by Staff developer.

initiated on 4/28/16

(Cont on pg 35B)

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| 441 | Continued From page 34 Findings were reviewed with E1 (NHA) and E2 during the exit conference on 3/31/16 at approximately 2:15 PM. | F 441 | <p>(cont from pg. 35A)</p> <p>3.) C. The Policy and Procedure on Contact Precautions and gloves will be in-serviced to all Staff and all new hires by the Staff Developer with observations of staff and their adherence, ongoing by the Staff Developer daily</p> <p>D. Direct Contact Precautions observations of glove use protocol and audits will be completed daily until 100% compliance over 3 consecutive evaluations. Then, weekly until 3 consecutive evaluations reach 100%, then biweekly until 3 consecutive evaluations reach 100%, then monthly ongoing to ensure compliance. All results will be brought to the facility QAPI meeting for further evaluations and recommendations.</p> | By 5/26/2016 |



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights Healthcare and Rehab Center, LLC DATE SURVEY COMPLETED: March 31, 2016

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|--|---|--------------------|
| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from March 22, 2016 through March 31, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical record and other facility documentation as indicated. The facility census the first day of the survey was 159. The Stage 2 survey sample was 32.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 31, 2016: F253, F278, F279, F315, F323, F371, F431, and F441.</p> | <p>See CMS 2567</p> | <p>5/26/16</p> |

Provider's Signature *Kristen B. Powell* Title *NHA* Date *4-21-16*