

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

PRINTED: 06/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2015
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NAME OF PROVIDER OR SUPPLIER KENTMERE REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LOVERING AVENUE WILMINGTON, DE 19806
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual recertification survey was conducted at this facility from June 1, 2015 through June 11, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 97. The Stage 2 survey sample size was 28. Findings include:</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA- Nursing Home Administrator; DON- Director of Nursing; LPN- Licensed Practical Nurse; CNA- Certified Nurse's Aide; FSD- Food Service Director; EMR - Electronic Medical Record; FCS- Delaware Monthly Functional Care Summary/form required by Medicaid; DE - Delaware; MRR-Medication Regimen Review; MDS- Minimum Data Set (standardized assessment forms used in nursing homes); MAR - Medication Administration Record; BIMS - Brief Interview for Mental Status-tool to measure mental abilities; L - left; ml-milliliter; pt - patient; ROM - Range of Motion/extent to which a joint can be moved safely; AAROM - Active Assisted Range of Motion; BID-twice a day; CKD - Chronic Kidney Disease/failure of kidneys to clean blood of impurities; Hemodialysis - procedure that removes waste</p>	F 000	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. Submission of this plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cileen Mable</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/17/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 and extra fluid from the body; PT-Physical Therapy/Therapist; OT-Occupational Therapy/Therapist; POA - Power of Attorney; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; B/L (b/l)-bilateral-on both sides; w/c-wheel chair; H & P - Health and Physical; ADL - Activities of Daily Living, such as dressing and bathing; Stroke-damage to the brain from interruption of its blood supply; Spork - cutlery in the form of a spoon-like shallow scoop with two to four fork tines; Gout - a complex form of arthritis characterized by sudden, severe attacks of pain, redness and tenderness in joints, often at the base of the big toe; Parkinson's disease - a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination.	F 000			
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;	F 272	A. A correction of R87 MDS was completed 6/10/15 by the Resident Assessment Coordinator. B. All residents with pain are at risk for being affected by this deficient practice. The Registered Nurse Assessment Coordinator (RNAC)/Designee will complete a random audit of at least 10 residents on each unit to assure that the MDS is accurately coded. C. The RNAC will be educated by the Staff Developer that medications not coded as analgesia, but utilized for pain management need to be coded as a pain regime on the MDS.	8/11/2015	

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F 272	<p>Continued From page 2</p> <p>Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R87) out of 28 Stage 2 sampled residents the facility failed to ensure the accuracy of the comprehensive assessment. Findings include: Review of R87's May, 2015 MAR revealed this resident was receiving the medication Gabapentin twice daily for chronic pain.</p> <p>The 5/11/15 admission MDS assessment stated under the Pain Management question that R87</p>	F 272	D. Registered Nurse Assessment Coordinator (RNAC)/Designee will complete monthly random audit of at least ten residents on each unit (Attachment 1) to assure that the MDS is accurately coded. The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed.	8/11/2015

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F 272	Continued From page 3 was not on a scheduled pain medication regimen. The facility failed to accurately complete the 5/11/15 MDS assessment. Findings were acknowledged by E2 (DON) during an interview on 6/10/15 at 11:30 AM.	F 272			
F 280 SS=D	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 record review and interview, it was determined the facility failed for one (R6) out of 28 Stage 2 sampled residents to review and revise the care plan after each assessment. Findings include:	F 280	A. Resident R6 was assessed by the Rehabilitation Director and a care plan for range of motion left hand/ fingers was revised by Registered Nurse, Second floor on June 9, 2015. B. All residents were reviewed to assure a care plan was in place for residents with range of motion limitations. C. The annual range of motion (ROM) Rehabilitation assessment form was revised July 8, 2015 (Attachment 2). When a limitation is identified thru assessment, the care plan will be initiated. D. Director of Nursing (DON)/Designee will complete a monthly random audit of range of motion assessments on at least ten residents on each unit (Attachment 3) to assure that appropriate care plans are in place. The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed.	8/11/2015	

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F 280	Continued From page 4 Cross refer, F318 R6 had a care plan, developed on 10/2/14, for the problem "at risk of developing contractures and/or limitation in motion..." This care plan included the intervention for AAROM to b/l shoulders, elbows, knees and ankles twice daily for 15 minutes. Although the facility periodically reviewed the care plan, it failed to revise the care plan to include interventions to increase ROM, as possible, to R46 left hand fingers. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/5/15 at approximately 4:30 PM.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with physician's orders for one (R46) out of 28 Stage 2 sampled residents. The facility failed to consistently monitor and/or adhere to fluid restriction requirements for R46. Findings include:	F 309	A. We cannot retroactively address the discrepancy in amounts of fluid given prior to and during survey. B. All residents with a fluid restriction were reviewed by the Dietitian by June 30, 2015 to ensure that the proper amounts of fluids are being given. C. (1) Staff Developer and Dietitian will inservice Nursing, C.N.A.'s and Dietary staff regarding the policy on fluid restriction and how to accurately calculate fluid intake. (2) It is now the responsibility of the 11 to 7 nurse to coordinate and total the fluid allotments documented on the MAR's and on the C.N.A.s meal intake records. Totals will now be reviewed in morning meeting by the Interdisciplinary Team and nurses will assess the resident's hydration status as indicated and the physician will be contacted accordingly.	8/11/2015

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F 309	<p>Continued From page 5</p> <p>R46 had a diagnosis of chronic kidney disease (CKD) and received hemodialysis three times a week at an outside facility.</p> <p>R46 had a physician's order, dated 1/28/15, for a fluid restriction of 1500 ml per day, Dietary=1,020 ml; Nursing: 7AM- 3PM = 240 ml; 3PM-11PM= 120 ml; 11PM-7AM = 120 ml.</p> <p>Review of the facility's EMR revealed that nursing was documenting it's fluid allotments on the MAR, and the dietary allotment was documented by CNAs on meal intake records.</p> <p>Review of the MAR from 2/1/15 through 3/6/15 lacked evidence of any monitoring of fluid amounts by nursing.</p> <p>R46's total fluid amounts were reviewed and revealed that on multiple occasions the restricted amount of 1500 ml per day was exceeded as follows: 1/1/15 = 1820 ml; 1/4/15 = 2420 ml; 3/8/15 = 2040 ml; 3/23/15 = 1560 ml; 3/27/15 = 1660 ml; 5/2/15 = 1620 ml; 5/11/15 = 1560 ml; 5/17/15 = 1560 ml; 5/31/15 = 1560 ml 6/1/15 = 1780 ml; 6/8/15 = 1680 ml.</p> <p>On 6/5/15 R46 was observed at breakfast. R46's meal ticket stated "Fluid Restriction: 2 - 8 ounce cups at breakfast; 1- 8 ounce cup at lunch and dinner." After R46 left the dining room his fluid</p>	F 309	<p>D. (1) The Registered Dietitian/designee will audit a weekly audit of all residents (Attachment 4) on a fluid restriction to determine if (a) the restriction is being followed, (b) fluids are being calculated accurately, (c) nurses are assessing resident's hydration status when indicated (D) that the physician is contacted accordingly. (2) The compliance rate will be reported at the facility Quality Assurance meeting until 100% is achieved for three months and ongoing as needed.</p>		

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F 309	Continued From page 6 totals were totaled by this surveyor as follows: apple juice=60 ml, milk=180 ml, coffee (2 cups) = 440 ml, for a total of 680 ml. Review of the CNA meal consumption record revealed a total of 480 ml was documented for breakfast on 6/5/15. This was a difference of 200 mls. The facility failed to accurately calculate R46's fluid intake and failed to adhere to the allotted fluid restriction amount for breakfast. On 6/5/15, R46 was observed at lunch. R46 had a 12 ounce can of Sprite, totaling 360 mls. Review of the CNA documentation on the meal intake record stated a total of 120 mls, a difference of 120 mls. The facility failed to accurately calculate R46's fluid intake and failed to adhere to the allotted fluid restriction amount for lunch. On 6/10/15 at 9:40 AM findings were acknowledged by E2 (DON).	F 309			
F 318 SS=G	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 observation, record review and interview, it was determined that the facility failed to ensure that one resident (R6), with a limited	F 318	A. On 6/5/2015 Resident R6 was immediately assessed by the Rehabilitation Director and a contracture management program for bilateral hands was implemented. B. A complete house audit was conducted by June 11, 2015 to assess for limitation in hand range of motion. Updates were made to appropriate contracture programs.	8/11/2015	

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F 318	<p>Continued From page 7</p> <p>ROM, out of 28 Stage 2 sampled residents, received appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM. The facility failed to identify and assess R6's limitation in ROM of the left hand on admission and failed to develop and implement an individualized ROM program that included the affected left extremity. Findings include:</p> <p>On 6/1/15 at 12:00 PM, during Stage 1 of the survey, R6 was observed seated in a w/c in his room with the 3rd, 4th and 5th fingers of the left hand in a closed position against the palm and scratching the left side of head with 1st finger which he was able to extend. No movement was observed of the last 3 fingers of his left hand.</p> <p>During a staff interview during Stage 1 with E10 (LPN) on 6/1/15 at 1:49 PM, E10 stated R6 had a contracture to his left hand and did not receive any ROM exercises and did not wear a splint.</p> <p>R6 was originally admitted to the facility on 8/6/14 with diagnoses that included stroke, gout, and Parkinson's disease.</p> <p>The 8/6/14 Admission Nursing Assessment under "ROM Limitations" did not identify any issues and was left blank, and also stated there was no limitation of the left upper extremity and that R6 was able to move it.</p> <p>The 8/7/14 Medical History and Physical (H&P) identified R6 as having full ROM of the upper extremities.</p> <p>The 8/8/14 OT Evaluation and Plan of Treatment did not identify any limitations of R6's left hand.</p>	F 318	<p>C. (1) The Rehabilitation Director has updated the ROM Assessment Form (Attachment 2) to include hand/fingers. (2) The ROM Assessment will no longer be conducted annually the assessment will now be completed upon admission, readmission, quarterly, annually and with a significant change. (3) Therapy staff will be inserviced by the Rehabilitation Director on use of the revised form by July 9, 2015.</p> <p>D. (1) The Assistant Director of Nursing (ADON)/Designee will complete weekly audits to monitor that ROM assessments were conducted on all residents that were admitted, readmitted, who had a quarterly/annual assessment or had a significant change. (2) The Assistant Director of Nursing/Designee will also monitor that all residents that were identified with limitations are receiving a contracture management program (Attachment 3) The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed.</p>	8/11/2015	

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F 318	<p>Continued From page 8</p> <p>The 8/8/14 PT Evaluation and Plan of Treatment did not identify any limitations of R6's left hand.</p> <p>On 8/11/14 the therapy department completed an annual ROM Assessment. Although this form did not include ROM measurements of the hands and fingers, it stated the resident presents with no limitations.</p> <p>According to the 8/13/14 admission MDS assessment, R6's vision was severely impaired, the BIMS indicated his daily decision making skills were intact, and he required extensive assist of one staff person for bed mobility, transfers, dressing, eating, toilet use and hygiene. This same MDS stated that R6 had no functional impairments in ROM of the upper extremities.</p> <p>Physician's recertification visits, dated 8/15/14 and 9/3/14, did not note any issues with ROM.</p> <p>The DE Monthly FCS, review period 9/4/14 to 10/1/14, stated R6 had no contractures. This review failed to identify and document R6's left hand ROM limitations.</p> <p>On 9/30/14 a physician's order stated for R6 to have AAROM to b/l shoulders, elbows, knees and ankles BID x 15 minutes on contracture management program. This contracture management program failed to include exercises to R6's hands and fingers. Review of physician's orders from 9/30/14 through 5/21/15 revealed this order was renewed on a monthly basis.</p> <p>On 10/1/14 the facility developed a care plan for the problem "Resident is at risk of developing</p>	F 318			

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F 318	<p>Continued From page 9</p> <p>contractures and/or limitation in motion secondary to diagnosis of generalized weakness and generalized pain." The goal was "ROM or contractures will improve or experience/exhibit no worsening, observable or measurable, by next review in 90 days." Interventions included: "Active assist range of motion exercises to bilateral shoulders, elbows, knees and ankles BID x 15 minutes daily (again did not include R6's hands); assess response to ROM exercises at least monthly, noting observable changes status quo; consult with therapist, PT/OT, as necessary..."</p> <p>A physician's recertification visit, dated 10/1/14, did not note any issues with ROM.</p> <p>The DE Monthly FCS, review period 10/2/14 to 10/29/14, stated R6 had no contractures.</p> <p>A quarterly MDS assessment, dated 11/5/14, stated R6 had no functional impairment in ROM of the upper extremities.</p> <p>A physician's recertification visit, dated 11/6/14, noted full ROM and weakness of both upper extremities. R6's left hand ROM limitation was not noted.</p> <p>The DE Monthly FCS, review period 10/30/14 to 11/26/14, 11/27/14 to 12/24/14, and 12/25/14 to 1/21/15, stated R6 had no contractures.</p> <p>Review of the EMR revealed R6 was hospitalized from 12/23/14 through 12/30/14. R6 was re-admitted to the facility on 12/30/14.</p> <p>The 12/30/14 Admission Nursing Assessment noted R6 had no ROM limitations of the upper extremities and again failed to identify and assess</p>	F 318			

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F 318	<p>Continued From page 10</p> <p>R6's left hand limitation in ROM.</p> <p>A physician's recertification visit, dated 1/9/15, did not note any issues with ROM of the upper extremities and/or left hand.</p> <p>The DE Monthly FCS, review period 1/22/15 to 2/18/15, stated R6 had no contractures.</p> <p>A physician's recertification visit, dated 1/29/15, stated R6 had full ROM.</p> <p>A quarterly MDS assessment, dated 2/4/15, stated R6 had no functional impairment in ROM of the upper extremities.</p> <p>The DE Monthly FCS, review period 2/19/15 to 3/18/15 and 3/19/15 to 4/16/15, stated R6 had no contractures.</p> <p>A physician's recertification visit, dated 3/20/15, stated R6 had full ROM and did not note any issues with ROM of the upper extremities and/or left hand.</p> <p>Review of the EMR revealed R6 was hospitalized from 3/24/15 through 4/6/15.</p> <p>The 4/6/15 Admission Nursing Assessment stated under the section Physical Status that "yes" there was "ROM Limitations" of the left upper extremity. However, there was no description of what the limitation was under the "comment" section. Additionally this assessment also noted there was no musculoskeletal limitation of the upper extremity and that R6 was able to move the left upper extremity.</p> <p>On 4/13/15, a rehabilitation screening was</p>	F 318			

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F 318	<p>Continued From page 11</p> <p>completed to determine if there was a need for therapy services. This screen stated R6 appeared to be at baseline and there were no current therapy needs.</p> <p>Physician recertification visits, dated 4/16/15 and 4/30/15, did not note any limited ROM of the left upper extremity.</p> <p>The DE Monthly FCS, review period 4/17/15 to 5/14/15, stated R6 had no contractures.</p> <p>A quarterly MDS assessment, dated 5/6/15, stated R6 had no functional impairment in ROM of the upper extremities.</p> <p>Review of the EMR revealed R6 was hospitalized from 5/13/15 through 5/21/15.</p> <p>The 5/22/15 Admission Nursing Assessment stated there were no ROM limitations of the left upper extremity.</p> <p>On 5/22/15, a rehabilitation screening was completed to determine if there was a need for therapy services post hospitalization. This screen stated R6 was at baseline and there were no current therapy needs.</p> <p>A physician's order, dated 5/26/15, stated "OT clarification order Therapy not recommended."</p> <p>Review of ADL Flow Sheets from 10/1/14 through 5/31/15 revealed CNAs were signing off completion of AAROM twice a day for 15 minutes to both shoulders, elbows, knees and ankles, except for times of hospitalization. There was no evidence of any ROM being provided to R6's wrists and hands.</p>	F 318			

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F 318	Continued From page 12 The following observations and/or interviews were conducted: 6/4/15 at 11:20 AM - R6 was observed seated in w/c in his room, holding a large foil snack bag between the left thumb and 1st finger and did not show any effort to move the other three fingers. After completing the snack R6 was observed scratching the left side of his head with his extended left first finger, the last three fingers remained closed against his palm. R6 was asked if he was able to open all the fingers of his left hand? He stated "No, cause of arthritis." 6/5/15 at 8:00 AM - lying on bed, left hand last 3 fingers pressed down against palm. 6/5/15 at 10:40 AM - during interview with E8 (CNA), she stated that she has taken care of R6 since she started in the facility in February, 2015. E8 stated she completes ROM exercises to his arms and legs during morning care and tries to open up his left hand during care to check the skin and to look that nails are clipped and not digging into the palm. E8 also stated that R6's left hand has been like this since she started caring for him. She stated that she is only able to open it slightly, maybe a 1/4 of the way, and then R6 will say that its starting to hurt a bit. 6/5/15 approximately 3:00 PM - observed R6's left hand with E6 (Rehab Director); E6 stated she was not able to locate any documentation in therapy notes of any ROM limitations of R6's left hand. E6 stated that one PT did say that he believes R6 "had something" with the hand but nothing was documented as the resident was able to utilize a rolling walker. E6 stated currently R6 was able to open the left thumb and index fingers, however there was a limitation of the 3rd,	F 318			

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F 318	<p>Continued From page 13</p> <p>4th and 5th fingers.</p> <p>6/5/15 at 4:25 PM - during an interview with E1 (NHA), E2 (DON) and E6 findings were reviewed. E1 stated that R6 has not had a decline in function, as he is able to feed himself with use of adaptive equipment. It was pointed out by the surveyor that R6 is right handed and uses that hand for holding eating utensils, and that he only uses the left thumb and 1st finger when holding anything in his left hand.</p> <p>A Rehab Screening Form, dated 6/5/15, stated "...seen today for L hand ROM assessment...found to have full extension of L thumb and index finger and limited extension of 3rd, 4th, and 5th digits. Spoke with nursing who reports pt function remains the same despite limited finger extension...Feel no splinting device is warranted at this time. Feel splinting device may inhibit pt functional use of hand as well as potential of splint to create pressure area. Will add ROM to L hand on contracture management program at this time." This is the first time the left hand was added to the contracture management program in over a 3 month period after it was established.</p> <p>A progress note, dated 6/6/15 and timed 4:37 PM, stated "Therapy completed a screen related to L hand ROM assessment. Resident was found to have full extension of L thumb and index finger and limited extension of 3rd, 4th and 5th digits...Call placed to POA....to discuss findings of the Therapy Screen...stated that she (POA) is aware and that resident has experienced this issue for '2 years or longer',..."</p> <p>In a surveyor interview on 6/11/15 at 9:10 AM with F1 (R6's family member), she stated she usually</p>	F 318		

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F 318	<p>Continued From page 14</p> <p>visits once a week. When asked about the resident's left hand, F1 stated "When he was in his apartment (prior to admission to facility), it was like that, it was starting. Now it's worse, he cannot open it and use it like he used to."</p> <p>During an interview on 6/11/15 at 10:07 AM with E6 and E7 (PT), who treated R6 when first admitted, E6 stated that everyone admitted gets an initial ROM assessment completed and that going forward there will be a change to add hands as part of the assessment. E7 stated she worked with R6 when he was first admitted and again in March. E7 also stated that there was a limitation of the left hand when he first came in, but it was not documented. E7 stated that, as a PT, she would look at gross motor function, transfer ability and if they can function with what they have. E7 stated the resident gets agitated when you try to work with his hand. E7 also said, "I didn't address his hands because the feeling was it has been there a long time, so he works around it. We assumed that it was his baseline for that hand. He had a limitation before he got here according to his daughter." E6 stated "with his behaviors, we do not want to cause pain, not best practice. We will look at changing our form. As a PT, I would make note of the hand, lesson learned. I will be more diligent about my documentation."</p> <p>Review of supplemental documentation submitted by the facility on 6/17/15 stated that R6 was able to grasp the handle of a standard rolling walker which measures 4 & 9/16th inches. This same document stated the facility implemented a formal ROM program to the digits on 6/5/15. After implementation of the ROM program to the digits the PT assessment dated 6/16/15 measures the</p>	F 318			

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F 318	Continued From page 15 hand grasp of a hollow dowel at 5 & 3/4th inches. This demonstrates an increase in ROM after a ROM program was instituted. The facility failed to accurately assess R6 on admission and on multiple occasions by multiple disciplines. The facility failed to identify the need to implement a contracture management program for the left hand [prior to 6/5/15]. There is no evidence the facility completed monthly monitoring for a decline in ROM (as there was no documentation of any limitation of the left hand to begin with) as per the care plan and no evidence of any services provided in an attempt to increase ROM and/or prevent further decrease. Although interviews confirmed that R6 entered the facility with some degree of limitation in ROM of his left hand, there is no documentation as to the extent of the limitation and a family member confirmed that, "Now it's worse, he cannot open it and use it like he used to." The facility failed to provide treatment and services to increase ROM or to prevent further decrease in ROM. Findings were discussed with E1, NHA and E2 on 6/11/15 at approximately 3:00 PM.	F 318			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369	A. Resident R6 was immediately provided a sectional plate and right spork at time of survey.	8/11/2015	

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F 369	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined for one (R60) out of 28 Stage 2 sampled residents that the facility failed to provide special eating equipment and utensils (assistive devices) for a resident who needed them. Findings include:</p> <p>R6 was admitted to the facility on 8/6/14 with diagnoses that included stroke, gout, and Parkinson's disease.</p> <p>The care plan for ADLs, last revised 3/7/15, stated R6 was to have assistive devices for meals - sectional plate, right spork and a 2 handled cup with lid.</p> <p>According to the most recent quarterly MDS assessment, dated 5/6/15, R6's vision was severely impaired, the BIMS indicated his daily decision making skills were intact, and he required set up help only and supervision while eating.</p> <p>R6 was observed on 6/5/15 at 8:55 AM eating breakfast in his room. R6 had a right spork, but no sectional plate or 2 handled lid with cup. E10 (LPN), who came into the room after the surveyor, stated she would go and get a 2 handled cup.</p> <p>On 6/10/15 at approximately 9:00 AM, R6 was observed in his room eating breakfast. R6 did not have a sectional plate and was using a small teaspoon (no right spork) to feed himself oatmeal. Additionally, a 2 handled cup was on the tray, but was not in use. Instead there was a large Styrofoam cup with a lid and straw. R6 was</p>	F 369	<p>B. (1) All residents with adaptive feeding equipment will be audited by the Food Service Director (FSD) to assure that adaptive equipment is placed on meal ticket. (2) The D.O.N./designee will audit the C.N.A. flow records of all residents that have adaptive equipment to monitor that the task was added to the electronic record.</p> <p>C. (1) The Staff Developer and Food Service Director will inservice Nursing and Dietary staff regarding adaptive feeding device usage on appropriate residents. (2) Now adaptive equipment will be added to the C.N.A. electronic charting system to be signed off by the aide for every meal. (3) Now adaptive equipment will be added to the resident's meal tickets.</p> <p>D. (1) On a weekly basis the Registered Dietitian/Designee will review physician orders for adaptive equipment against meal tickets, and the C.N.A. charting system for accuracy. (2) On a weekly basis, the FSD/Designee will complete an audit during meal time of 50% of residents with adaptive equipment to monitor for accuracy (Attachment 5).(3) The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed.</p>	8/11/2015	

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F 369	Continued From page 17 observed feeding himself the oatmeal with the small spoon. R6 was unable to grasp the spoon correctly resulting in spillage of oatmeal onto his shirt. R6 was asked about using a 2 handled cup, to which he stated that he didn't always get it and using it does make it easier for him. E9 (LPN) entered the room during this time and was asked about the assistive devices. E9 then went out and verified that a right spork, a sectional plate and 2 handled cup with lid were to be used for all meals. E9 acknowledged the assistive devices were not in use.	F 369			
F 371 SS=F	The facility failed to ensure that R6 received the assistive eating devices as per the plan of care. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: During a kitchen tour with E10 (FSD) on 6/1/15 the following observations were made:	F 371	A. On 6/1/2015 during kitchen tour with surveyor, the Food Service Director addressed: 1. The thermometer was actually in place at the time of survey, but was not clearly visible. The thermometer was moved into the direct line of vision when you open the refrigerator by the Food Service Director (FSD). 2. Ice machine curtain was cleaned on 6/1/2015 by the FSD. 3. Maintenance Department will correct air gap ice machine curtain by 7/8/2015. 4. Maintenance staff corrected the air gap for the prep sink on 6/4/2015. 5. Hand washing sign posted at hand washing sink 7/8/15.	8/11/2015	

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F 371	Continued From page 18 1. At approximately 9 AM, the first floor pantry refrigerator lacked a thermometer to insure that food was stored under proper temperatures. 2. The interior surface and filter of the ice machine in the main kitchen had mildew. 3. The ice machine in the main kitchen had an ineffective air gap of less than 6 inches. 4. The food prep sink in the main kitchen had an ineffective air gap of less than 6 inches. 5. There was no hand washing sign posted at the hand washing sink in the main kitchen. Findings were confirmed with E10 during the kitchen tour. Findings were reviewed with E1 (NHA) on 6/1/15 at approximately 1:30 PM.	F 371	B. All residents have the potential to be affected by this deficient practice. C. The FSD/designee will make weekly rounds to monitor; thermometer, clean ice machine curtain, air gap ice machine and prep sink and hand washing sign (Attachment 6). D. The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed by the FSD/designee.	8/11/2015
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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	A. The facility cannot retroactively address the narcotic signatures that were not completed for narcotic counts on dates ranging from April to June 2015. B. Narcotic counts on all shifts on all medication carts have the potential to be affected by this deficient practice.	8/11/2015

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F 431	<p>Continued From page 19</p> <p>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 record review and staff interview, it was determined that the facility failed to ensure that a system of records (Narcotic Shift Count Sheet), kept for the receipt and disposition of all controlled medications, was conducted by two (2) licensed nurses at each shift. This deficient practice was found on three (3) out of three (3) floors/units, two (2) of which had two (2) medication carts each, and one (1) which had one (1) medication cart (total of 5 medication carts). Findings include:</p> <p>Review of the narcotic count sheets from 4/1/15 through 5/31/15 revealed missing nurse on and/or nurse off signatures for Cart #1 (first floor) on the following dates:</p>	F 431	<p>C. (1) The Director of Nursing will develop a policy on Narcotic counts at change of shift (Attachment 7). (2) The Staff Developer will inservice all licensed nurses on new Policy for Narcotic Count. The policy includes the need to have the signature of both the on coming and off going nurse. (3) Now the House Supervisors will check the narcotic sheets at the end of each shift to monitor that sheets have the signature of both the on coming and off going nurse. Any discrepancies will be reported to the D.O.N. for follow up.</p> <p>(D) (1) The Unit Manager /Designee will conduct weekly audits of all Controlled Count Records to monitor that the form is being properly maintained including double signatures and that discrepancies were reported to the D.O.N. A random audit of Narcotic Counts will be conducted Monthly by the Director of Nursing/designee (Attachment 8). (2) The Compliance rate will be reported at the facility Quality Assurance meeting until 100% is achieved for three months and ongoing as needed.</p>	8/11/2015

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F 431	<p>Continued From page 20</p> <p>4/2/15, 4/5/15, 4/6/15, 4/7/15, 4/23/15, 4/29/15, 5/3/15, 5/5/15, 5/7/15 through 5/11/15, 5/15/15, 5/16/16, 5/18/15, 5/19/15, 5/21/15, 5/22/15, 5/24/15, 5/25/15, and 5/26/15.</p> <p>Review of the narcotic count sheets from 4/1/15 through 6/10/15 revealed missing nurse on and/or nurse off signatures for Cart #2 (first floor) on the following dates: 4/16/15, 4/21/15, 4/25/15, 5/1/15, 5/8/15, 5/20/15, 6/1/15, 6/2/15, 6/5/15, 6/8/15 and 6/9/15.</p> <p>Review of the narcotic count sheets from 4/1/15 through 6/10/15 revealed missing nurse on and/or nurse off signatures for Cart #3 (second floor) on the following dates: 4/1/15, 4/2/15, 4/6/15, 4/21/15, 4/24/15, 4/26/15, 4/30/15, 5/2/15, 6/2/15, and 6/7/15.</p> <p>Review of the narcotic count sheets from 4/1/15 through 6/10/15 revealed missing nurse on and/or nurse off signatures for Cart #4 (second floor) on the following dates: 4/4/15, 4/8/15, 4/22/15, 4/23/15, 4/27/15, 4/28/15, 4/30/15, 5/12/15, 5/14/15, 5/26/15, 5/30/15, 5/31/15, and 6/2/15.</p> <p>Review of the narcotic count sheets from 4/1/15 through 6/10/15 revealed missing nurse on and/or nurse off signatures for Cart #5 (third floor) on the following dates: 4/1/15, 4/8/15, 4/11/15, 4/16/15, 4/17/15, 4/18/15, 4/27/15, 4/30/15, 5/11/15, 5/13/15, 5/17/15, 5/19/15, 5/20/15, 5/28/15, 5/29/15, 5/31/15, 6/3/15, and 6/5/15.</p> <p>During an interview on 6/11/15 at 1:48 PM with E2 (DON) she stated she was unable to locate a policy/procedure for narcotic change of shift</p>	F 431			

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: 085001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER KENTMERE REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LOVERING AVENUE WILMINGTON, DE 19806	
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F 431	Continued From page 21 counts. E2 stated the expectation was for 2 nurses to complete the narcotic count at change of shift, oncoming and off going. If a nurse works a double shift and continues to work the same cart, then a count would be done at next change of shift when the keys to the cart are relinquished.	F 431		
F 441 SS=F	Findings were discussed with E1, NHA and E2 on 6/11/15 at approximately 3:00 PM. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program 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	F 441	A. On June 1, 2015 a hand sanitizer dispenser was placed on the soiled side of Laundry room by Maintenance Staff. B. All residents have the potential to be affected by this deficient practice. C. Laundry staff will be inserviced regarding hand hygiene by the Staff Developer/designee. D. On an ongoing basis, the Environmental Director/designee will make weekly rounds in the Laundry to monitor 10 opportunities for hand hygiene compliance (Attachment 9). The Compliance rate will be reported at the facility Quality Assurance meeting until 100% is achieved for three months and ongoing as needed by the Environmental Service Director/designee.	8/11/2015

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F 441	Continued From page 22 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 observation and interview it was determined that the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Findings include: During a tour of the laundry area on 6/1/15 at approximately 1 PM with E11 (Housekeeping Supervisor) it was determined that laundry staff did not have immediate access to a hand washing sink or a way to wash their hands when going between the washing and drying areas. Findings were confirmed with E11 during the laundry area tour. Findings were reviewed with E1 (NHA) on 6/1/15 at approximately 1:45 PM.	F 441			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM- ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463	A. The shower stall in question was taken out of service on July 1, 2015, until the Electrical contractor could determine if an Emergency call light could be added to the third floor shower stall. A quote for placement of the call light was received July 1, 2015 and approved.	8/11/2015	

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F 463	Continued From page 23 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to maintain a working communication system in all of the bathing facilities. Findings include: During the tour of the third floor shower room with E11 (Housekeeping Supervisor) on 6/1/15 at approximately 2 PM it was determined that the Emergency Nurse call cord was missing in the middle shower stall. In case of an emergency with residents in the indicated area, staff would not be able to access them in order to provide help. This shower area is used by multiple residents. Findings were confirmed with E11.	F 463	B. All residents have the potential to be affected by this deficient practice. C. Yellow caution tape and signage "Do not use" was placed on shower stall without emergency cord on July 2, 2015. D. (1) The House Keeping Director will conduct weekly Environmental Rounds to monitor that the yellow caution tape and signage is still intact and that the third floor shower stall without emergency cord is not being utilized (Attachment 10). (2) New emergency cord installation approved and pending. E. The results of the weekly Environmental audit will be discussed in morning meeting and during the monthly Safety meeting until the Emergency call light is installed.	8/11/2015	
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 services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	A. The facility cannot retroactively address the lack of documentation of monthly pharmacy review in the medical record B. All residents have the potential to be affected by this deficient practice. On Tuesday, June 30, 2015 an audit of all residents was completed by the Director of Nursing. Inconsistencies in expected reviews and documentation in the medical record were discovered. In coordination with the Pharmacist, June's monthly review of medications was then completed and placed in the Medical Record by June 30, 2015.	8/11/2015	

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F 514	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the clinical records on 2 (R67 and R56) out of 28 Stage 2 sampled residents, were maintained in accordance with accepted professional standards and practices that are complete, readily accessible and systematically organized. Findings include: 1. Review of R67's EMR failed to contain documentation of a November, 2014 MRR review by a Pharmacist. In an interview with E2 (DON) on 6/5/2015 at approximately 2:00 PM, the November 2014 results of MRR "Consultation Report" form from the Pharmacist contained a list of names of 85 residents that included R67 was maintained in the facility. However, this review form was not part of R67's clinical record, the EMR and/or in this resident's chart that contained other medical records. According to E2 on 6/5/2015 at approximately 2:00 PM, she stated that it was maintained in the facility and for privacy purposes, this "Consultation Report" form could not be placed in R67's chart because it contained the list of names of the other 85 residents that were reviewed. The facility's results of MRR were not documented in a consistent location to facilitate communication with physicians, nursing staff, surveyor, legal representative and authorized others and in accordance with accepted professional standards and practices that are complete, readily accessible and systematically organized.	F 514	C. Based on the audit of June 30, a revised facility process was reviewed with the Pharmacist to ensure that all residents are reviewed by pharmacy and that review is present in the medical record. D. On a monthly basis, the Director of Nursing/designee will audit all residents to assure the monthly Pharmacy review is completed. (Attachment 11). The Compliance rate will be reported at the facility Quality Assurance meeting until 100 % is achieved for three months and ongoing as needed.	8/11/2015	

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F 514	<p>Continued From page 25</p> <p>2. Review of R56's EMR failed to show documentation of an April, 2015 MRR by a Pharmacist in accordance with accepted professional standards and practices. In an interview with E2 on 6/10/2015 at 8:54 AM, E2 confirmed that the April 2015 MRR was not present in R56's clinical record. The Pharmacist gave the facility a hard copy of a form entitled "Consultation Report" dated April 1, 2015 through April 30, 2015 that contained a list of 75 residents' names that included R56's name and indicated that a MRR was done for these residents. However, the results of R56's MRR was not documented in this resident's EMR and/or in this resident's chart.</p> <p>The facility failed to maintain a complete clinical record for R56 that is in accordance with accepted professional standards and practices when R56's record was absent of the April 2015 MRR.</p> <p>Findings were discussed with E1, NHA and E2 on 6/11/15 at approximately 3:00 PM.</p>	F 514		
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**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: Kentmere Rehabilitation and Healthcare Center **DATE SURVEY COMPLETED:** June 11, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual recertification survey was conducted at this facility from June 1, 2015 through June 11, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 97. The Stage 2 survey sample size was 28. Findings include:</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA- Nursing Home Administrator; DON- Director of Nursing; LPN- Licensed Practical Nurse; CNA- Certified Nurse's Aide; FSD- Food Service Director; EMR - Electronic Medical Record; FCS- Delaware Monthly Functional Care Summary/form required by Medicaid; DE - Delaware MRR-Medication Regimen Review MDS- Minimum Data Set (standardized assessment forms used in nursing homes); MAR - Medication Administration Record; BIMS - Brief Interview for Mental Status-tool to measure mental abilities; L - left; ml-milliliter; pt - patient; ROM - Range of Motion/extent to which a joint can be moved safely; AAROM - Active Assisted Range of Motion; BID-twice a day; CKD - Chronic Kidney Disease/failure of kidneys to clean blood of impurities;</p>	<p>Cross Refer to the 2015 Federal Plan of Correction CMS 2567 F272, F280, F309, F318, F369, F371, F431, F441, F463, and F514.</p>	<p>8/11/2015</p>
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Provider's Signature Eileen Malle Title Administrator Date 7/17/15



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NAME OF FACILITY: Kentmere Rehabilitation and Healthcare Center **DATE SURVEY COMPLETED:** June 11, 2015

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>Hemodialysis - procedure that removes waste and extra fluid from the body;</p> <p>PT-Physical Therapy/Therapist;</p> <p>OT-Occupational Therapy/Therapist;</p> <p>POA - Power of Attorney;</p> <p>Contracture - joint limitations with fixed high resistance to passive stretch of a muscle;</p> <p>B/L (b/l)-bilateral-on both sides;</p> <p>w/c-wheel chair;</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>		

Provider's Signature Eileen M. Kelly Title Administrator Date 7/17/15



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This requirement is not met as evidenced by: Cross Refer Cross to the CMS 2567-L survey completed June 11, 2015 F272, F280, F309, F318, F369, F371, F431, F441, F463, and F514.

Provider's Signature *Elton M. Kelly* Title *Administrator* Date *7/17/15*