

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

PRINTED: 08/17/2016
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 07/18/2016
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 survey was conducted at this facility from July 11, 2016 through July 18, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 94. The Stage 2 survey sample size was 30.</p> <p>Abbreviations / definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RNAC - Registered Nurse Assessment Coordinator; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; UM - Unit Manager; ADLs (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Bacteriuria - presence of bacteria in the urine; Care Area Assessment (CAA) - summary of the MDS assessment which assists in identifying and planning for potential problem care areas; Chronic - of long duration; Contenance - control of bladder and/or bowel function; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Diuretic - medication that rids the body of excess fluid and causes increased urination; EMR - Electronic Medical Record; e.g.-for example;</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

07/28/2016

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 Etc-et cetera-and so forth; Frequently incontinent - seven (7) or more episodes of urinary incontinence, during the seven day review period, but at least one (1) episode of continent voiding; Hyperlipidemia - high cholesterol &/or triglycerides (fat proteins) associated with increased risk for heart disease and stroke; i.e.-that is; Incontinence/incontinent - loss of control of bladder and/or bowel function; Lipid Profile - blood tests for cholesterol & triglycerides (fat proteins); Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Minimum Data Set (MDS) - standardized assessment tool used in long term care facilities; Occasionally incontinent - less than seven (7) episodes of incontinence during the seven (7) day review period; Pravastatin - medication used for high cholesterol; r/t - related to; s/sx - signs and symptoms; Supra-pubic catheter - a hollow flexible tube inserted into the bladder through a cut in the abdomen, a few inches below the navel (belly button) used to drain urine from the bladder; Total Assistance - full staff performance of an activity; Urinary Tract Infection (UTI) - bacteria in the urine; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days; (+) - positive.	F 000			
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		9/6/16	

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F 225 SS=D	<p>Continued From page 2</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the other facility documents, it was determined that the facility failed to ensure that an allegation that had the potential for emotional abuse for one (R8) out of 30 Stage 2 sampled residents, was reported immediately to the State Agency. Additionally, the facility failed to have documented evidence that this allegation was thoroughly investigated. Findings include:</p> <p>The facility's Administrative Policy entitled "Investigation Protocol", effective date July 2016, stated, "...to attempt to determine if abuse...to provide appropriate follow-up including intervention to prevent further incidents. Procedure...1...The investigator will maintain neutrality and conduct an impartial investigation. 2...The investigation will be thorough, prompt, and include data collection and analysis. Investigator Responsibilities 1. Log the alleged event on an incident report via computer/manual tracking form (Resident Incident Monitoring Log)...Documentation must provide evidence that alleged violations are thoroughly investigated (i.e., summary report, copies of record, summary witness statements, etc.)...Complete and submit summary of findings of investigation to State within five (5) working days of incident. Include summary of any corrective action..."</p> <p>Review of R8's clinical record revealed: R8's 6/25/16 quarterly MDS assessment stated that R8 was cognitively intact.</p> <p>7/11/16 at 11:48 PM, a nurse's note stated " At about 1900 (7:00 PM) staff (unknown) reported to</p>	F 225	<p>A. The Director of Nursing, Social Service Director and Licensed Certified Social Worker spoke with R8 and resident was not negatively impacted by the allegation of abuse.</p> <p>B. All residents progress notes are being evaluated to determine if there are any allegations of abuse documented/reported by August 5, 2016.</p> <p>C. All nurses will be inserviced by the Staff Developer regarding identifying and reporting allegations of abuse.</p> <p>D. DON/designee will complete a monthly random audit of all records to determine that allegations of abuse are reported/documented. Results will be reported to the facility Quality Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.</p>		

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F 225	Continued From page 4 this writer (E10 RN) that Resident slapped her (unknown staff) on her face. This writer went to Resident's room, Resident appeared to be angry, Resident states 'am going to report that girl to the State tomorrow she was laughing at me'. Resident calm and relaxed at this time". During an interview with E2 (DON) on 7/15/16 at 10:20 AM, she stated that there was no incident report for this occurrence. 7/15/16 at approximately 3:30 PM, E10 (RN) and E2 were interviewed. E10 stated that she investigated the situation, however, she did not write an incident and an investigation report. E10 and E2 stated that the allegation of staff laughing at her was part of R8's behavior problems. There was no documented evidence in the clinical record of R8's behavior of previous allegations of staff laughing at her. The facility failed to recognize that R8's statement was an allegation that had the potential for emotional abuse. The facility failed to ensure that the alleged incident was recorded on an incident report and was thoroughly investigated with documented evidence of such.	F 225		
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.	F 280		9/6/16

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F 280	<p>Continued From page 5</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for 2 (R8 and R62) out of 30 Stage 2 sampled residents, the facility failed to ensure that their care plans were reviewed and/or revised after each assessment. Findings include:</p> <p>1. Review of R8's clinical record revealed: For R8, the facility developed a care plan entitled UTI-Altered urinary elimination related to (+) bacteriuria, effective 5/6/16.</p> <p>Review of R8's record revealed that this resident had a supra-pubic catheter. The care plan interventions included: - monitor for signs and symptoms of UTI such as painful urination, frequency and urgency, etc.; - encourage frequent voiding to promote bladder emptying. These interventions were not appropriate since R8 had a supra-pubic catheter.</p>	F 280	<p>A. R8 and R62s plans of care were updated to reflect the current urinary status. R8s plan of care was revised. Inappropriate interventions were removed that detailed to monitor for signs and symptoms of UTI such as painful urination, frequency and urgency. Also removed were interventions to encourage frequent voiding to promote bladder emptying. The care plan interventions will be updated to include that R8 is changing her own drainage bag and that education and staff monitoring is occurring periodically. R8 and R62 were not negatively impacted by the inappropriate interventions documented on the plan of care B. All urinary care plans will be reviewed to determine that the appropriate interventions are in place.</p>	

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F 280	Continued From page 6 Additionally, on 7/18/16 at approximately 12:20 PM, E2 (DON) stated that R8 changes her own supra-pubic drainage bag. The care plan interventions failed to include that R8 was changing her own drainage bag and that education and staff monitoring was occurring periodically. The facility failed to ensure that R8's care plan was revised to reflect appropriate interventions for supra-pubic catheter care. Findings were reviewed with E2 and confirmed on 7/18/16 at approximately 4:30 PM. 2. Cross refer to F315 Review of R62's clinical record revealed: R62 has resided at the facility for multiple years and has diagnoses that included abnormalities of gait and mobility, muscle weakness and chronic pain syndrome. 1/10/14 - A care plan for occasional urinary incontinence r/t altered mobility and inability to always voice need to urinate was developed. Interventions included: Observe for s/sx of UTI, toilet resident on toilet/commode to promote complete emptying of bladder, toilet per toileting schedule and as needed, incontinence care after each incontinent episode. 4/9/16 - The quarterly MDS assessment stated that during the seven (7) day review period R62 was frequently incontinent of bladder. This was a decline from the previous 1/8/16 annual MDS assessment, when R62 was occasionally incontinent.	F 280	C. The Unit Manager/RNAC will review the urinary plan of care after completing the bowel and bladder assessment to determine if the plan of care needs to be revised. Any resident with a decline will receive further assessment and the appropriate care plan update. The Staff Developer will inservice all nurses regarding appropriate interventions for residents with suprapubic catheter. D. DON/designee will complete a monthly audit of 10 records per unit to determine that urinary interventions on the plan of care are appropriate. Results will be reported to the facility Quality Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.	

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F 280	Continued From page 7 The facility failed to revise R62's incontinence care plan when a decline in continence status occurred.	F 280		
F 312 SS=E	Findings were confirmed by E2 (DON) during an interview on 7/14/16 at approximately 2:00 PM. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and review of facility documentation, it was determined that for 2 (R66 and R46) out of 30 Stage 2 sampled residents, the facility failed to ensure those residents, who were unable to carry out activities of daily living (ADLs), received the necessary services to maintain good grooming. For R66, the facility failed to ensure he maintained good grooming as evidenced by multiple observations of being unshaven and having jagged fingernails. In addition, the facility failed to ensure that R66 was bathed twice a week according to his plan of care. For R46, the facility failed to ensure fingernail cleanliness was maintained. Findings include: The facility policy entitled "Bathing and Grooming", dated May 2016, stated, "To ensure that all residents are bathed, shaved, and receive fingernail care, as appropriate, to maintain	F 312	A. R66 was assessed to determine the time of day that he would be most receptive to receiving a shower and grooming. R46 had hand hygiene and nail trimming immediately at time of survey. B. Facility audit of grooming will be completed to assure that showers and nail care are completed. C. Facility policy will be revised to include nail care to be completed at the time of shower at least twice each week. Staff Developer will inservice CNAs on new grooming policy. D. Evening Supervisor/designee will complete a random monthly audit of at least 10 residents on each unit to determine that showers and grooming are completed according to policy. Results will be reported to the facility Quality	9/6/16

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F 312	<p>Continued From page 8</p> <p>cleanliness and a sense of well-being...Tub baths or showers are given by all nursing staff twice a week, or as necessary...Follow bathing schedule posted on each unit...Males and females, as appropriate, will have facial hair removed/shaved every other day...Finger nail care will be completed as scheduled, on the CNA assignment sheet...".</p> <p>1. Review of R66's clinical record revealed: R66 was readmitted to the facility on 7/23/15 with diagnosis including dementia.</p> <p>On 8/8/15, R66 was care planned for ADLs that included total assistance for bathing due to impaired cognition with an approach to provide a tub/shower two times a week and nail care.</p> <p>Review of R66's CNA documentation record regarding bathing revealed the following: May 2016 - bathed 4 out of 9 scheduled times; June 2016 - bathed 1 out of 9 scheduled times; and July 1 - 17, 2016 - bathed 0 out of 4 scheduled times.</p> <p>Review of R66's progress notes from May 1, 2016 through July 17, 2016 lacked evidence of R66 refusing bathing and/or grooming services.</p> <p>Observations of R66 included the following: - on 7/11/16 at 2:52 PM, observed unshaven with jagged fingernails. - on 7/13/16 at 4:34 PM, observed unshaven. - on 7/14/16 at 11:53 AM, observed unshaven with jagged fingernails. - on 7/15/16 at 11:43 AM, observed with jagged fingernails. This surveyor asked E5 (LPN, UM) to look at R66's fingernails. E5 immediately obtained</p>	F 312	Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.		

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F 312	<p>Continued From page 9</p> <p>nail clippers to trim R66's fingernails.</p> <ul style="list-style-type: none"> - on 7/15/16 at 3:26 PM, observed unshaven. - on 7/18/16 at 9:19 AM, observed clean shaven. <p>In an interview on 7/18/16 at 9:37 AM, E6 (CNA) stated that R66 was to be bathed on Mondays and Thursdays on the 11 PM to 7 AM shift. E6 stated that R66 requires total assist of one staff person for bathing, shaving and nail care.</p> <p>In an interview on 7/18/16 at 10 AM, findings were reviewed with E5 regarding multiple observations over 5 days of R66 being unshaven until today. E5 confirmed the finding after reviewing R66's clinical record and stated he was not aware of R66 not receiving scheduled showers since May 2016.</p> <p>The facility failed to ensure that R66, a resident who is unable to carry out ADLs, received the necessary services to maintain good grooming, personal hygiene and bathing. Findings were reviewed with E2 (DON) on 7/18/16 at 10:08 AM.</p> <p>2. Review of R46's clinical record revealed: R46's care plan for ADLs, effective 12/14/13, stated the resident was dependent for personal hygiene. An intervention included for staff to provide assistance for a daily sponge bath and twice weekly tub/shower and nail care.</p> <p>The 6/17/16 annual MDS assessment stated R46's cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) and that R46 was totally dependent on one staff person for hygiene and bathing.</p> <p>Observations on 7/12/16 at 10:04 AM and</p>	F 312		

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F 312	Continued From page 10 7/14/16 at 11:06 AM revealed R46 with dark colored debris under the fingernails of the left hand. In an interview on 7/14/16 at 11:07 AM, E7 (LPN) confirmed R46's left hand fingernails were dirty. E7 proceeded to clean R46's fingernails. The facility failed to provide R46, who was unable to carry out activities of daily living, the necessary services to maintain good grooming and personal hygiene. Findings were reviewed with E1 (NHA) and E2 on 7/18/16 at approximately 5:50 PM during the exit conference.	F 312		
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 clinical record review, interviews and review of other facility documents as indicated, it was determined that for one (R62) out of 30 Stage 2 sampled residents, the facility failed to ensure that a resident who was incontinent of	F 315	A. R62 had a bowel and bladder reassessment performed at the time of survey. The plan of care was updated to reflect current status. B. Nursing Management will review all	9/6/16

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F 315	<p>Continued From page 11</p> <p>bladder received appropriate treatment and services to restore as much normal bladder function as possible. The facility failed to re-assess R62 when a decline in bladder continence occurred, and failed to develop an individualized toileting plan. Findings include:</p> <p>The facility nursing policy titled "Incontinence (treatment)," dated 6/30/06, stated, "...PROCEDURE: Incontinence is assessed on admission. 1. Section H of the MDS in (sic) completed on admission, on re-admission, quarterly and with significant change. Identify those residents who are incontinent, or have experienced a decline in continence. 2. On admission, all residents...should have a voiding diary completed. The diary need only be completed with new incontinence or changes in incontinence patterns (decline)...3. Complete the diary for two days (48) hours, evaluating the resident every 2 hours...4. After 48 hours, review the Voiding Diary to determine if there is a voiding pattern...Complete the Incontinence Assessment...5. If a toileting plan is developed, monitor the planned toileting times and its results for one month. Modify the schedule as needed...".</p> <p>A revised nursing policy titled "Incontinence Assessment and Management," effective June 2016, stated, "...PROCEDURE: 1. Upon admission, all residents will be assessed for incontinence using the Bowel and Bladder Diary. 2. Complete the diary for three days (72 hours). 3. After 72 hours, review the Voiding Diary to determine if there is a pattern of incontinence...Complete the Bowel and Bladder Assessment and develop an appropriate plan of care...6. On a quarterly basis and with a decline in continence status, the facility will complete a</p>	F 315	<p>bowel and bladder assessments to determine if there are residents with decline in status. MDS assessments will be reviewed to assure that current status is reflected.</p> <p>C. The Nursing Assessment for Bowel and Bladder will be revised with definitions to match the MDS coding. All residents with decline in urinary or bowel function will be reassessed and a toileting plan will be added to the plan of care as appropriate.</p> <p>Staff Developer will inservice all nurses on the revised bowel and bladder assessment.</p> <p>D. RNAC/designee will complete a monthly random audit of at least 10 records per unit to determine that bowel and bladder assessments are accurate and that the MDS reflects the current status. Results will be reported to the facility Quality Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.</p>		

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F 315	<p>Continued From page 12</p> <p>bowel and bladder assessment. Based on the assessment, a voiding diary will be initiated and the plan of care will be revised if necessary."</p> <p>Review of R62's clinical record revealed the following:</p> <p>R62 had resided at the facility for multiple years and had diagnoses that included abnormalities of gait and mobility, muscle weakness and chronic pain syndrome.</p> <p>1/10/14 - A care plan, target date 7/18/16, for occasional urinary incontinence r/t altered mobility and inability to always voice need to urinate was developed. Interventions included: Observe for s/sx of UTI, toilet resident on toilet/commode to promote complete emptying of bladder, toilet per toileting schedule and as needed, incontinence care after each incontinent episode.</p> <p>2/1/15 through 2/28/15 - Review revealed that this was the last time R62 was on a toileting program.</p> <p>1/1/16 through 1/31/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had 14 episodes of urinary incontinence.</p> <p>1/6/16 - A quarterly Bowel and Bladder Assessment was completed. This assessment stated: - there were no changes in factors affecting bowel and bladder function; - there was no change in management of bladder function; - R62 was continent of bladder. This assessment was inaccurate, as the electronic CNA Documentation History Detail</p>	F 315			

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F 315	<p>Continued From page 13</p> <p>report revealed R62 was having episodes of urinary incontinence.</p> <p>1/8/16 - R62's annual MDS assessment stated that during the seven (7) day review period:</p> <ul style="list-style-type: none"> - daily decision making skills were moderately impaired (decisions poor; cues/supervision required); - required extensive assist of two (2) staff for transfers and toilet use; - had not walked in the room or corridor; - was occasionally incontinent of bladder (four [4] episodes of urinary incontinence during the review time period); - received a diuretic daily during the seven (7) day review period. <p>The CAA portion of the 1/8/16 annual MDS assessment triggered incontinence as a potential problem area and was checked off to proceed with care planning.</p> <p>2/1/16 through 2/29/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had seven (7) episodes of urinary incontinence.</p> <p>2/9/16 - A quarterly Bowel and Bladder Assessment was completed after R62 was re-admitted to the facility post hospitalization and again erroneously stated R62 was continent of bladder.</p> <p>3/1/16 through 3/31/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had 16 episodes of urinary incontinence.</p> <p>4/1/16 through 4/30/16 - Review of the electronic CNA Documentation History Detail report for</p>	F 315			

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F 315	<p>Continued From page 14</p> <p>bladder continence revealed R62 had 24 episodes of urinary incontinence.</p> <p>4/5/16 - A quarterly Bowel and Bladder Assessment was completed and again erroneously stated R62 was continent of bladder.</p> <p>4/9/16 - A quarterly MDS assessment stated that during the seven (7) day review period R62: - daily decision making skills were moderately impaired (decisions poor; cues/supervision required); - required extensive assist of two (2) staff for transfers and toilet use; - had not walked in the room or corridor; - was frequently incontinent of bladder (nine episodes of urinary incontinence during the review time period); - received a diuretic daily during the seven (7) day review period.</p> <p>After completion of the 4/9/16 MDS assessment, the facility failed to identify R62's decline in urinary continence, they failed to re-assess R62, and failed to develop an individualized toileting plan based on established voiding patterns (voiding diary). Additionally, the facility failed to revise R62's plan of care to address the decline in urinary continence.</p> <p>5/1/16 through 5/31/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had 13 episodes of urinary incontinence.</p> <p>6/1/16 through 6/31/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had 19 episodes of urinary incontinence.</p>	F 315			

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F 315	Continued From page 15 7/1/16 through 7/14/16 - Review of the electronic CNA Documentation History Detail report for bladder continence revealed R62 had 13 episodes of urinary incontinence. 7/4/16 - A quarterly Bowel and Bladder Assessment was completed and once again erroneously stated R62 was continent of bladder. 7/13/16 at approximately 2:30 PM - The electronic CNA Assignments Summary, which lists the care CNAs are to provide for R62, was printed. It stated R62 was continent of bladder, used the toilet, wore an incontinence brief, and to "SEE TOILETING SCHEDULE." As already stated, the last documented evidence of R62 being on a scheduled toileting plan was back in February, 2015. 7/14/16 at 11:19 AM - In an interview with E9 (CNA), R62's assigned aide that day, she stated that when she got the resident up and into the bathroom that despite a slightly wet brief, R62 did also urinate into the toilet. E9 stated that as far as she was aware, R62 does ask to be taken to the bathroom when she needs to go. E9 stated that she was not aware of R62 being on any scheduled toileting plan. This surveyor and E9 then checked the binder on the unit where CNAs document if a resident is on a scheduled toileting plan. There was no scheduled toileting plan found for R62. 7/14/16 at 11:41 AM - During an interview, E8 (RNAC) confirmed that according to the MDS assessments, R62 had a decline from occasionally incontinent (1/8/16 MDS) to frequently incontinent (4/8/16 MDS). E8 stated	F 315			

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F 315	<p>Continued From page 16</p> <p>that when there is a decline the resident should be re-assessed and have a new voiding diary completed. E8 stated that when a decline is noted, she goes to speak with the UM and then the "team" will decide if a toileting plan would help or not. E8 was not able to state whether this had occurred after completion of R62's 4/8/16 MDS assessment. Additionally, E8 confirmed that the last voiding diary completed for R62 was dated 6/24/14.</p> <p>7/14/16 at 2:10 PM - During an interview with E2 (DON) the findings were confirmed. E2 stated that the facility felt they had an issue/concern with their incontinence management program and had revised the policy, which went into effect in June 2016. E2 stated that she personally went through all the resident's bowel and bladder assessments, and those who were incontinent had a new voiding diary completed. E8 stated she reviewed R62's Bowel and Bladder Assessment, but because it stated the resident was continent no further action was taken.</p> <p>7/14/15 at approximately 4:00 PM - E4 (RN/UM), who completed R62's Bowel and Bladder Assessments from 1/16 through 7/16, was interviewed. When asked how she determined R62's continence status, E4 stated that she calculated percentages and if the resident had a higher percentage of being continent then that was what she documented as the resident's status (e.g. if 92% of the time R62 was continent then she marked continent.).</p> <p>The facility failed to ensure that a resident who is incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible. Per the</p>	F 315			

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F 315	Continued From page 17 4/9/16 quarterly MDS assessment, R62 had a decline from occasionally incontinent to frequently incontinent. There was no evidence the resident was re-assessed, no voiding diary completed, no evidence of an individualized toileting plan, and no revision to the resident's plan of care. Although the incontinence care plan stated R62 was on a toileting plan, the last documented evidence of scheduled toileting was back in February of 2015.	F 315		
F 329 SS=D	7/18/16 at approximately 5:30 PM - findings were reviewed with E1 (NHA) and E2 during the exit conference. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/6/16

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F 329	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the facility failed to have two (R126 and R112) out of 30 Stage 2 sampled resident's drug regimen free from unnecessary medications. The facility failed to monitor the resident's lipid profile periodically as indicated for Pravastatin, a medication for Hyperlipidemia. Findings include: The product information for Pravastatin, last revised 7/2016, stated, "... Adult Patients...Since maximal effect of a given dose is seen within 4 weeks, periodic lipid determinations should be performed at this time and dosage adjusted according to the patient's response to therapy and established treatment guidelines ...". 1. Review of R126's clinical record revealed: R126 was admitted to the facility on 9/30/14 with Pravastatin medication included in her daily medication therapy. Review of R126's clinical record from August 2015 to July 13, 2016 lacked evidence of the facility monitoring the resident's response to the Pravastatin therapy. In an interview on 7/14/16 at 11:15 AM, E5 (LPN, UM) confirmed the finding. On 7/14/16 at 12:55 PM, a physician's order was written to perform a lipid panel every 6 months in	F 329	A. R112 and R126 had a lipid panel completed immediately. B. A focus audit of all residents on statins was completed and lipid panels were ordered as appropriate. C. A process was implemented for all residents who receive statins to have a lipid panel drawn at least annually. Staff Developer will inservice all nurses on the process for ordering annual lipid panels. D. ADON/DON /designee will complete a monthly audit of all records to determine that appropriate lipid panels have been ordered for residents receiving statin. Results will be reported to the facility Quality Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.		

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F 329	Continued From page 19 July and January. The facility failed to ensure that R112 was being periodically monitored for the response to the Pravastatin medication. Findings were reviewed with E2 (DON) on 7/18/16 at 10:10 AM. 2. Review of R112's clinical record revealed: R112 was admitted to the facility on 11/26/14 with Pravastatin medication included in her daily medication therapy. Review of R112's clinical record from August 2015 to July 13, 2016 lacked evidence of the facility monitoring the resident's response to the Pravastatin therapy. In an interview on 7/15/16 at 3:32 PM, E5 confirmed the finding that a lipid profile was not performed since August 2015. The facility failed to ensure that R112 was being periodically monitored for the response to the Pravastatin medication. Findings were reviewed with E2 on 7/18/16 at 10:10 AM.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		9/6/16	

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F 428	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the monthly MRR, completed by the consultant pharmacist, failed to identify the lack of monitoring of efficacy of Pravastatin for two (R126 and R112) out of 30 Stage 2 sampled residents. Findings include: The product information for Pravastatin, last revised 7/2016, stated, "... Adult Patients ... Since maximal effect of a given dose is seen within 4 weeks, periodic lipid determinations should be performed at this time and dosage adjusted according to the patient's response to therapy and established treatment guidelines ...". Cross refer to F329, example 1 1. Review of R126's clinical record revealed: R126 had a physician's order for daily Pravastatin since admission to the facility on 9/30/14. Review of R126's pharmacy reviews from August 2015 to July 2016 revealed the consultant pharmacist's failure to identify that R126 was not getting lipid determinations performed periodically as indicated while taking Pravastatin. In an interview on 7/14/16 at 11:15 AM, E5 (LPN, UM) confirmed the finding. Findings were reviewed with E2 (DON) on 7/18/16 at 10:10 AM. Cross refer to F329, example 2 2. Review of R112's clinical record revealed: R112 had a physician's order for daily Pravastatin	F 428	A. R112 and R126 had a lipid panel completed immediately. B. The Consultant Pharmacist will review all residents during the monthly August audit to assure that residents on statins have a lipid panel within the past year. C. The Consultant Pharmacist will review all residents each month to determine that residents on statins have an annual lipid panel. D. DON/designee will complete a monthly audit of all residents to assure that residents on statins have a lipid panel within the past 12 months or as ordered by physician. Results will be reported to the facility Quality Assurance Committee. The compliance rate will be reported until three months of 100% compliance is achieved.	

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F 428	Continued From page 21 since admission to the facility on 11/26/14. Review of R112's pharmacy reviews from August 2015 to July 2016 revealed the consultant pharmacist's failure to identify that R112 was not getting lipid determinations performed periodically as indicated while taking Pravastatin. In an interview on 7/15/16 at 3:32 PM, E5 confirmed the finding. Findings were reviewed with E2 (DON) on 7/18/16 at 10:10 AM.	F 428		



**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: July 18, 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 July 11, 2016 through July 18, 2016. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 94. The survey sample totaled 30 residents.</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 July 18, 2016: F225, F280, F312, F315, F329 and F428.</p>	<p>Cross refer to CMS 2567-L F225, F280, F312, F315, F329, and F428.</p>	<p>9/6/2016</p>

Provider's Signature Eileen M. Maly Title Administrator Date 8/5/2016