STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 05/08/2014

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KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 29, 2014 through May 8, 2014. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 100. The Stage 2 survey sample totaled 31 residents which included review of 28 active records and 3 closed records.	F 000	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.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	A. (1.) R61 no longer resides in the facility. (2.) R57 and R162 physicians are now being notified of any change in condition and of nutritional recommendations. B. All residents that have a change in condition and any residents that have nutritional recommendations made by the dietitian are at risk for being affected by this deficient practice. C. (1) The facility will begin attaching the corresponding progress notes to the 24 Hour Report. Both the 24 hour report and progress notes will be reviewed in the morning meeting. The progress notes is a way of tracking physician notification regarding resident's change in condition, and if nutritional recommendations were reported to the physician. (2) The Staff Developer/ Designee will educate licensed nurses on the facility's policy regarding "Notification of Resident Change in	6/16/2014 7/7/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Eileen Mahle — Administrator — 6/3/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and review of facility documentation, it was determined that three (R57, R61 and R162) out of 31 Stage 2 sampled residents reviewed, the facility failed to immediately notify the physician when there were significant changes in R57 and R61's blood pressure/BP (pressure exerted by the circulating blood on the walls of the blood vessels). R57 had a blood pressure of 200/90 which was high and R61's blood pressure measured 87/50 which was low. Additionally, the facility failed to notify R162's physician in a timely manner, of the dietitian's recommendation to give this resident a dietary supplement. Findings include: The facility policy entitled, "Notification of Resident Change in Condition", dated 7/13, stated, "To ensure that all appropriate, interested parties are notified of significant changes in a resident's health ... 3. Related to medical care, the charge nurse will notify ... the resident's physician ... when there is ... significant change in condition in physical ... status ...". The facility policy entitled, "Vital Signs (assess the body functions which included blood pressure)", dated 12/09, stated, "... Blood Pressure ... 1. The average blood pressure is 120/80. You should	F 157	Condition". (3) The Staff Developer/ Designee will educate licensed nurses on the need to notify the physician regarding nutritional recommendations made by the dietitian. (4) The Staff Developer/Designee will educate the Unit Managers/Dietician to attach the progress notes to the 24 Hour Report. (5) The Dietitian will now provide the D.O.N. with a log of the nutritional recommendations made so implementation can be tracked. D. On an ongoing basis the 24 Hour Report and the corresponding progress notes will be reviewed in morning meeting. Weekly the D.O.N./designee will calculate the compliance rate for physician notification regarding resident's change in condition, and if nutritional recommendations were reported to the physician (Attachment A). Compliance rate will be reported in monthly QA & A until 100% compliance is achieved for 3 months and ongoing as needed.	7/7/2014 6/16/2014 7/1/2014

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immediately report a blood pressure greater than 150/90 or less than 90/60."

1. R57 was admitted to the facility on 11/13/13.

According to a nurse's progress note, dated 3/31/14 and timed 11:24 PM, "... monitoring continues post (after) vital signs, blood pressure 200/91 at 4:30 PM, rechecked at 9:00 PM, it was 180/86 ...".

R57's clinical record lacked evidence that the facility immediately notified the physician for this resident's elevated BPs of 200/91 and 180/86.

In an interview with E11 (Registered Nurse/RN) on 5/6/14 at 3:55 PM, she stated that she did not recall notifying the physician of R57's elevated BP of 200/91. E11 confirmed that the physician should have been notified immediately.

Findings were reviewed with E2 (Director of Nursing/DON) on 5/7/14 at 4:00 PM.

2. R61 was admitted to the facility on 2/16/14.

A physician's order, dated 2/16/14 and timed 6:52 PM, stated to monitor vital signs every shift.

Review of the February 2014 Medication Administration Record revealed that R61's BP on 2/22/14 during the 3:00 - 11:00 PM shift was 87/50, which was below the normal range of 120/80 as per facility policy.

In an interview with E12 (RN) on 5/7/14 at 3:16 PM, E12 confirmed that she was the assigned nurse on 2/22/14 and she acknowledged that the BP reading of 87/50 was low for R61 and that the

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F 157	Continued From page 3 physician was not immediately notified of this significant change. Findings were discussed with E2 (DON) on 5/7/14 at 4:00 PM. 3. R162's dietary note, dated 4/26/14 and timed 4:04 PM, stated that the resident was underweight, had a poor to fair meal intake and a history of swallowing difficulty. R162 required a pureed diet (foods are blended until smooth and drinkable) with a honey thickened liquid consistency. The note stated that R162 was admitted with a pressure sore (open area of skin that develops when the blood supply to it is cut off due to pressure) and she had lost 3.6 pounds (4%) since her admission (4/18/14). The dietician recommended Med Pass (nutritional supplement) three times a day between meals, a multivitamin/mineral supplement, Vitamin C supplement "to assist with healing and to prevent further weight loss." R162's care plan, dated 4/30/14, for "Nutritional Status: Risk for Weight Loss Resident is at risk for weight loss...". Interventions included "... Provide diet and supplements as ordered..." On 5/5/14 at 2:00 PM, review of R162's April and May 2014 physician orders and Medication Administration Records (MARs) lacked evidence of the dietician's recommendations for a nutritional supplement. Further review on 5/6/14 at approximately 11 AM, revealed that the Med Pass supplement was ordered on 5/6/14 at 9:31 AM and added to R162's May 2014 MAR, but it was not administered.	F 157		

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F 157	Continued From page 4 During an interview on 5/7/14 at 8:40 AM, E6 (Dietician Consultant) stated that if she determined that a resident needed a supplement, she would enter the order into the computer and then the nurse would process it. E6 then showed the surveyor that the Med Pass order was dated as entered by her in the computer system on 5/5/14 and it was processed by a nurse on 5/6/14. E6 stated that she reviewed R162's weights, wound sheets, and dietary notes from the other consulting dietician on Monday (5/5/14). She also reviewed the orders and saw there was no order for Med Pass and so she entered it on 5/5/14. When asked if it should have taken this long for the resident to get started on Med Pass, she stated, "No, it doesn't usually take this long.... I plan to check the doctor's communication book for any communication of MVI (multivitamin), Vitamin C ... We don't write orders for those, only the doctor can do that." During an interview on 5/7/14 at 9:07 AM, E6 confirmed there was no documentation of the other dietician's recommendations for Med Pass or the other recommended vitamins in the doctor's book. E6 stated that she returned to work on 4/28/14 and was unaware of the other dietician's recommendations until she reviewed R162's weights on 5/5/14. The facility failed to notify the physician of the dietician's recommendations to add a supplement, Med Pass 4 oz (ounces) three times a day between meals and the multivitamin/mineral, and Vitamin C per day to assist with healing and to prevent additional weight loss for R162.	F 157		

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F 159	Continued From page 5	F 159	A. R10, R11, R96 earned interest have been posted to their trust fund account.	5/8/2014
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives	F 159	B. (1) All residents that have their personal fund allowance account managed by the facility are at risk for this deficient practice. (2) The Billing Manager/designee will audit all residents' accounts for the past 6 months to assess if the correct interest was applied to their accounts. Adjustments will be made accordingly.	6/9/2014
			C. (1) WSFS bank provided the facility with a letter confirming that resident's funds are in being held in an interest bearing account (Attachment B). (2) On a monthly basis the facility will begin a double check system to monitor that the correct interest has been applied to resident's accounts.	5/5/2014 6/9/2014
			D. (1) Monthly the Billing Manager/designee will audit resident's accounts to assess if the correct interest was applied to their accounts (Attachment C). Compliance rate of the monthly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/1/2014

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F 159	Continued From page 6 Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of quarterly statements of personal funds and staff interview, it was determined that the facility failed to ensure that three (R10, R11 and R96) out of 31 Stage 2 sampled resident's credits of interests were posted in their personal trust fund accounts. The facility confirmed that interest was not posted to any of the aforementioned residents' accounts. Findings include: Review of the facility admission packet included a form entitled, "Delegation of Authority for Management of Personal Allowance Account" which stated, "... hereby request (facility name) to manage a personal allowance account for me in an interest bearing checking account in a bank of its choice". 1. Review of R10's interest bearing fund quarterly "Trust Statements" with E6 (Consultant Bookkeeper) on 5/2/14 at approximately 9:30 AM revealed there was no credit interest posted in R10's trust fund account from 1/15/13 to 3/28/14. 2. Review of R11's interest bearing fund quarterly "Trust Statements" with E6 on 5/2/14 at approximately 9:30 AM, revealed there was no	F 159		

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F 159	Continued From page 7 credit interest posted in R11's trust fund account from 12/3/12 to 3/18/14. 3. Review of R96's interest bearing fund quarterly "Trust Statements" with E6 on 5/2/14 at approximately 9:30 AM revealed there was no credit interest posted in R96's trust fund account from 12/3/12 to 3/18/14. Findings were confirmed with E6 during an interview on 5/2/14 at approximately 9:30 AM. Additionally, on 5/2/14 at approximately 3:30 PM, E1 (Administrator) stated that the facility had switched banks and she confirmed that interest was not posted to any of the aforementioned residents' accounts. E1 stated that she would have this corrected right away.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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	F 225	A. The Division of Long Term Care (DLTCRP) has been notified of R69. R71, and R138 alleged violations along with the required 5 day follow up. B. All residents that have alleged violations are at risk for this deficient practice. C. During morning meeting all alleged violations will be reviewed by the Interdisciplinary Team (IDT). The IDT will monitor for the adherence of reporting and providing follow up to DLTCRP in accordance to state law. Additionally the IDT will review the thoroughness of investigations.	6/9/2014

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F 225	Continued From page 8 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation as indicated, it was determined that the facility failed to ensure that all alleged violations involving neglect or abuse, including injuries of unknown origin for three (R69, R71 and R138) out of 31 sampled residents, were reported immediately to the Division of Long Term Care Residents Protection (DLTCRP) and that all alleged violations were thoroughly investigated with results of the investigations reported to the State Agency (DLTCRP) within 5 working days of the incident. The facility failed to immediately report to the DLTCRP in accordance with State law a significant injury (bruise) of unknown origin for R71 and an unwitnessed fall with injury for R69. The facility also failed to report the results of	F 225	D. Weekly the NHA/designee will audit the timeliness of both reporting and following up with DLTCRP in accordance to state law. Additionally the thoroughness of investigations concerning alleged violations will be reviewed weekly (Attachment D). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/1/2014

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F 225	Continued From page 9	F 225		

R71's investigation to the DLTCRP within 5 working days of the incident. Additionally, the facility failed to thoroughly investigate an allegation with potential for neglect of care for R138. Findings include:

1. A nurse's note for R71 dated 11/29/13 and an incident report dated 11/29/13 stated, "Resident was noted with a bruise to right rib cage and right breast during AM (morning) care. Resident not able to tell what happened. Family and MD (Medical Doctor) informed".

During an interview with E2 (Director of Nursing/DON) on 5/7/14 at 1:30 PM, she stated R71's bruise was not measured, but it was large and significant. Although the bruise was significant, and in an area not vulnerable to trauma and R71 was unable to state what happened the facility failed to immediately report the incident to the DLTCRP. Additionally, the investigation was not initiated until 12/2/14 as per E2; therefore, the facility failed to report the results of the investigation to the DLTCRP within 5 working days of the incident. E2 confirmed findings.

2. An incident report regarding an unwitnessed fall for R69 by E2 (DoN) revealed that the resident was found on her bedroom floor mat on 3/26/14 at 4:30 PM with nasal (nose) bleeding noted. R69 was transferred to a hospital emergency room for further evaluation. A CT scan (imaging test that takes detailed pictures of the inside of the body) showed no acute (sudden onset) fracture (broken bone) or dislocation, but indicated that a "Mild deformity of the left nasal

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F 225	Continued From page 10 bone could reflect an acute fracture". This incident was reported 3 days later on 3/28/14 to the DLTCRP and not immediately as per established procedure. Cross-refer to F309 example 1 3. An incident report, dated 11/7/13, stated that on 11/7/13 at approximately 6:50 AM, E3 (Assistant Director of Nursing) knocked and entered R138's room to greet her. R138 was readmitted to the facility from the hospital late in the evening of 11/6/13. R138 stated to E3 that "last night was the worse night of my life... I haven't been moved all night". R138 was observed to be saturated with urine that soaked through her adult protective undergarment and onto her bed clothes. R138 also stated that she rang her call bell for assistance for 90 minutes prior to E3 coming into her room. E7 (night shift Certified Nurse's Aide/CNA assigned to R138) confirmed to E3 that she had not provided care to R138 her entire shift. Review of the incident report and other documents revealed that the facility failed to obtain statements from the charge nurse and other CNA's on that shift as to why they did not respond to R138's call bell or check on her. The facility investigation lacked interviews or any other supporting documentation to show why care was not provided for R138. Findings were confirmed with E1 (Administrator) and E2 during an interview on 5/8/14 at approximately 9:30 AM.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	A. E19 was educated on the need to knock and to ask permission before entering a resident's room; however E19 is no longer employed by the facility.	

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F 241	Continued From page 11 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain or enhance 2 (R93 and R143) out of 31 sampled residents' dignity and respect in full recognition of his or her individuality. During the medication (med) pass on 5/1/14 the facility failed to ensure staff knocked and/or requested permission to enter the resident's rooms prior to entering. Findings include: 1. During the med pass observation on 5/1/14 at approximately 9:05 AM and 9:10 AM, E19 (Licensed Practical Nurse/LPN) entered R93's room twice without knocking or asking permission to enter. Findings were discussed with E19 on 5/1/14 at approximately 3:15 PM. E19 stated that she went into R93's room to obtain vital signs before the med pass and she knocked before entering at that time and informed R93 that she would be back with R93's medications. E19 stated that R93 was expecting her back with the resident's meds so she did not believe it was necessary to knock again. Findings were reviewed and confirmed with E2 (Director of Nursing/DON) during an interview on 5/2/14 at 2 PM. 2. During the med pass observation on 5/1/14 at	F 241	B. All residents are at risk for this deficient practice. C. (1) The Staff Developer/designee will educate all departments on the need to knock and to ask permission before entering a resident's room. (2) Additionally this education will be added to new hire orientation, and to the annual mandatory in-service education review. D. The Staff Developer/designee will conduct random audits of observing staff entering resident's rooms, and monitor that the proper procedure was followed (Attachment E). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/7/2014 7/1/2014

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F 241	Continued From page 12 approximately 9:30 AM, E19 (LPN) entered R143's room twice- the first time she entered without knocking or asking permission to enter and the second time at approximately 9:35 AM she knocked and then entered without waiting for permission to enter. Findings were discussed with E19 on 5/1/14 at approximately 3:15 PM. E19 stated that she went into R143's room to obtain vital signs before the med pass and she knocked before entering at that time and informed R143 that she would be back with R143's medications. E19 stated R143 was expecting her back with the resident's meds so she did not believe it was necessary to knock again. Findings were reviewed and confirmed with E2 (DON) during an interview on 5/2/14 at 2 PM.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	A. R162's MDS was corrected to reflect the proper coding. B. All residents are at risk for being affected by this deficient practice. C. (1) The Registered Dietician will complete SigmaCare's electronic training and tutorials on MDS Coding for MDS 3.0. (2) On an ongoing basis the D.O.N./Registered Nurse Assessment Coordinator will be responsible for completing all tutorial updates offered by Sigmacare that pertain to MDS 3.0 coding.	5/8/2014 6/13/2014 6/2/2014

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F 272	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R162) out of 31 Stage 2 sampled residents, the facility failed to ensure the accuracy of the admission assessment in the area of a physician-prescribed weight loss program. Findings include: R162's admission Minimum Data Set (MDS) assessment, dated 4/25/14, stated that this resident was on a physician-prescribed weight loss program. R162 was prescribed a pureed diet with no added salt and honey thickened liquids. Review of R162's physician's orders lacked evidence of a	F 272	D. (1) The D.O.N./designee will audit various sections of the MDS for coding accuracy. The sample size of the audit will be 25% of the MDS's submitted monthly. (Attachment F). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/1/2014

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F 272	Continued From page 14 prescribed weight loss program. R162's Dietary Nutrition Risk Assessment, dated 4/26/14, stated that the resident had lost weight since admission and recommended a supplement to prevent further weight loss. During an interview on 5/3/14 at approximately 11:30 AM, findings were discussed and confirmed with E2 (Director of Nursing) and E4 (Registered Nurse Assessment Coordinator) who both stated that it was a coding error. The facility failed to ensure that R162's Admission MDS, dated 4/25/14, accurately reflected R162's status. On 5/6/14 at 9 AM, E4 provided a copy of R162's corrected MDS assessment.	F 272		
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 record review and interview, it was determined that the facility failed to ensure that three (R61, R138 and R143) residents out of 31 sampled, received the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial	F 309	A. (1) R138 no longer resides in the facility. (2) R143 discontinued medications were sent back to the pharmacy. B. (1) All residents who had a medication discontinued and residents that have parameters ordered with their medications have the potential to be affected by this deficient practice. (2) All medication carts will be checked for discontinued medication. Discontinued medications will be removed and returned to the pharmacy accordingly. (2) All residents that have parameters will have them typed into the electronic Medical Administration Record (MAR) in capital letters for better visibility.	5/8/2014 6/16/2014

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F 309	Continued From page 15 well-being, in accordance with the resident's comprehensive assessments and plans of care. R138 was readmitted to the facility from the hospital on the evening of 11/06/13. R138 wore oxygen and was totally dependent on staff for turning, repositioning, transfers and incontinence (loss of control of bladder and/or bowel function) care. On the night shift, staff made rounds at the beginning of the shift, but R138 was not provided care throughout the remainder of the shift. R138 was found saturated through her adult protective undergarment onto her bed clothes with urine at 6:50 AM, 90 minutes after she first rang her call bell for assistance at 5:20 AM. On 2/27/14, R61 was administered a medication when her blood pressure (pressure exerted by the circulating blood on the walls of the blood vessels) was 81/53 despite a physician's order to hold the medication if her systolic blood pressure (SBP/top number of the blood pressure) was less than 110. During the medication pass observation on 5/1/14 the facility failed to prepare medications as per R143's physician order and staff would have administered the incorrect dosage of medication if not stopped by the surveyor. Findings include: 1. Cross-refer to F353 R138 was readmitted to the facility after 5 days of hospitalization on 11/6/13 with diagnoses of Congestive Heart Failure (heart unable to pump enough blood to meet the body's needs) and Acute Renal Disease (sudden onset of kidneys not working properly). According to R138's significant change of status Minimum Data Set (MDS) assessment, dated 11/10/13, her skills for daily decision-making were "independent-decisions consistent and	F 309	C. (1) The facility will institute the following procedure; the nurse who writes the discontinuation order will also be required to pull the medication from the cart, and return the medication to the pharmacy (Policy/Procedure Attachment A). The Staff Developer/Designee will educate licensed nursing staff on the new procedure. (2) The facility will institute the following procedure; parameters will be inputted in the electronic MAR system in capital letters for better visibility (Policy/Procedure Attachment B). The Staff Developer/Designee will educate licensed nurses, nurse practitioners and physicians on this new procedure. D. (1) Weekly the D.O.N./designee will audit medication carts to monitor that discontinued medications were pulled and returned to the pharmacy (Attachment G). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as need. (2) Weekly the D.O.N./designee will audit 25% of the electronic MAR's to monitor that parameters were inputted in the computer with capital letters, and that medications were administered in adherence to the parameters (Attachment G). The compliance rate of weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/7/2014 7/1/2014

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reasonable". However, she was totally dependent on staff to carry out all of her activities of daily living (ADLs) such as bed mobility, transfers, and toileting care. R138 was readmitted with an open wound to her sacrum (large triangular bone at base of spine) and was assessed as always incontinent of bowel and bladder. R138 was dependent on oxygen.

The facility established the following care plans:
6/26/13 - "... high predictive factor for additional... skin breakdown secondary to impaired bed mobility..." interventions included, "assist to turn and reposition every 2 hours";
6/26/13 - "... dependent with assist of two for most ADL's" interventions included, "Provide assist of two for bed mobility, transfers as she wishes, and dressing...for incontinence, provide incontinence care after each episode".

Further review of R138's facility records and other documentation revealed the following:
On 11/7/13 at 6:30 AM, R138 reported to E3 (Assistant Director of Nursing) that "last night was the worse night of my life...I haven't been moved all night". At 6:30 AM E3 observed that R138's adult protective undergarment pad was saturated onto her bed clothes with urine. R138 stated to E3 that she was not moved, turned or changed during the 11:00 PM to 7:00 AM shift. R138 stated that she activated her call bell at 5:30 AM and no one came until E3 entered the room at 6:50 AM (90 minutes later) during her rounds to greet newly admitted/readmitted residents.

Review of the facility's investigation revealed the following:
E7 (Certified Nurses's Aide) was assigned to take care of R138. Shortly after R138 was readmitted

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F 309	Continued From page 17 to the facility, E7 "checked on the resident...looked into the room to make sure that the resident was safe in her bed, that she was breathing and that her bed was in the lowest position". E7 admitted she did not check on R138 again or provide her with any care throughout the remainder of her shift. R138 was not turned and repositioned every 2 hours as per her care plan and she was left wet in bed all night until 6:50 AM when E3 found the resident saturated with urine. Findings were confirmed with E2 (Director of Nursing) on 5/6/14 at 2:00 PM. 2. During the medication pass observation on 5/1/14 at approximately 9:30 AM, E19 (Licensed Practical Nurse/LPN) placed 2 tablets of Hyoscyamine (Levsin- for irritable bowel syndrome and increased oral secretions) 0.125 mg (milligram) tablets in the medicine (med) cup to administer to R143 instead of 1 tablet. R143 had a physician's order for Levsin 1 tablet 3 times a day that was discontinued on 4/29/14 and the Levsin was reduced to 1 tablet 2 times a day. There were 2 blister packs of Levsin in the med cart- one labeled 2 times a day and one labeled 3 times a day; E19 popped 1 pill from each of the blister packs so she had twice the ordered dose (0.25 mg) ready to give to R143. The error was identified when the surveyor's pill count did not match what E19 had in the med cup. After advising E19 of the pill count discrepancy she removed the extra Levsin tablet and administered R143's medications. E19 stated she would check with the charge nurse to look into the physician's	F 309		

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order for Levsin to see what was going on (after she administered R143's meds).

Findings were discussed with E19 on 5/1/14 at approximately 3:20 PM. E19 stated she could have checked the Levsin order on the electronic Medication Administration Record (on top of med cart), but she was nervous at the time and did not think of it. E19 stated after the med pass, she learned from the charge nurse that the Levsin 3 times a day order was discontinued on 4/29/14 and she stated that someone should have sent the blister pack back to the pharmacy the same day.

Findings were discussed with E2 (Director of Nursing) during an interview on 5/2/14 at 2 PM.

3. R61 was admitted to the facility on 2/16/14 with diagnoses including heart failure (heart unable to pump enough blood to meet the body's needs).

A physician's order, dated 2/25/14 and timed 7:53 AM, stated to hold Spironolactone (medication that helps reduce the amount of water/excess fluid in the body) if the SBP is less than 110.

Record review of the February 2014 Medication Administration Record revealed that R61's blood pressure was 81/53 on 2/27/14 during the 7:00 to 3:00 PM shift. Further review revealed that R61 was administered Spironolactone medication on 2/27/14 at approximately 9:00 AM despite a physician's order to hold the medication when the SBP was less than 110.

Findings were confirmed with E13 (Registered Nurse) during an interview on 5/7/14 at 3:06 PM.

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F 309	Continued From page 19 Findings were reviewed with E2 (Director of Nursing) on 5/7/14 at 4:00 PM.	F 309		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	A. The facility only offers Influenza immunization during the flu season which is from October 1 – March 31. The facility is not currently offering Influenza immunization. B. All residents that receive an Influenza immunization are at risk for being affected by this deficient practice. C. (1) The NHA & Nursing Management Team will review the facility's "Influenza Immunization Program" policies. Policies and procedures will be updated in accordance with the most current Standards of Practice (Policy/Procedure Attachment C). Additionally, consents will be obtained upon admission and education will begin to be offered to residents annually. (2) The Staff Developer will educate licensed nurses on the updated policies and procedures. 7/7/2014 D. During the flu season the D.O.N./designee will monitor that consents and education were provided to residents and/or to their responsible party (Attachment H). The results of these audits will be reported out in QA & A from October through March. 7/1/2014	

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F 334	Continued From page 20 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. 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 4 (R11, R12, R96 and R135) out of 5 sampled residents had documented evidence that the residents (or their legal representatives) were informed/educated on the benefits and potential side effects of receiving the influenza	F 334		

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F 334	Continued From page 21 vaccination. Findings include: The facility policy and procedure entitled "Influenza Immunization Program" was reviewed. Review of the facility's policy and procedure stated that residents would be offered an Influenza vaccine annually and if the vaccine was refused the facility should reeducate and offer the vaccine as indicated annually. 1. Review of the immunization record for R11 revealed that on 9/23/13, the resident received an Influenza immunization at the facility. However, R11's records lacked evidence that the Influenza immunization benefits and education of the possible risks was provided to the resident or their legal representative prior to receiving the vaccine. 2. Review of the immunization record for R12 revealed that on 9/23/13, the resident received an Influenza immunization at the facility. However, R12's records lacked evidence that the Influenza immunization benefits and education of the possible risks was provided to the resident or their legal representative prior to receiving the vaccine. 3. Review of the immunization record for R96 revealed that on 9/23/13, the resident received an Influenza immunization at the facility. However, R96's record lacked evidence that the Influenza immunization benefits and education of the possible risks was provided to the resident or their legal representative prior to receiving the vaccine. 4. Review of the immunization record for R135 revealed that on 9/23/13, the resident received an	F 334		

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F 334	Continued From page 22 Influenza immunization at the facility. However, R135's record lacked evidence that the Influenza immunization benefits and education of the possible risks was provided to the resident or their legal representative prior to receiving the vaccine. In an interview with E2 (Director of Nursing) and E4 (Registered Nurse Assessment Coordinator) on 5/1/14 at approximately 2:39 PM, E2 stated that the consents were obtained only once, upon admission to the facility and stated their procedures may need revision.	F 334		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	A. (1) On November 7, 2013 the facility met the legal staffing requirements outlined in the Eagles Law (2) R 138 no longer resides at the facility. (3) E18 is no longer is employed by the facility. B. All residents have the ability to be affected by the deficient practice. C. (1) Daily the D.O.N./designee and the Scheduler will meet to discuss and monitor the nursing schedule. The weekend schedule will be reviewed on Friday. They will monitor that the daily nursing schedule and staffing patterns promote the residents highest practical well-being as per their care plans. Adjustments will be made accordingly. (2) The monitoring of the call bell panel will be added to SigmaCare's Nursing Tasks, which require nursing signature each shift.	5/8/2014

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F 353	Continued From page 23 This REQUIREMENT is not met as evidenced by: Cross-refer to F309, example 1 Based on record review, interview and review of other facility documentation, it was determined that the facility failed to ensure that there was sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one totally dependent resident (R138) out of 31 sampled as determined by resident assessments and the individual plan of care. Findings include: R138, an alert and oriented resident was readmitted from the hospital on 11/6/13 on the evening shift. R138 needed to be turned every 2 hours related to a sacral (large triangular bone at base of spine) wound and to minimize exposure to moisture related to incontinence (loss of control of bladder and/or bowel function). During review of the facility records and other documentation, it was revealed that on 11/6/13 on the 11-7 AM (night) shift, R138 was not provided care, that is, she was not turned or repositioned and she was left wet all night until 6:50 AM. E3 (Assistant Director of Nursing) upon starting her shift around 6:50 AM entered R138's room to welcome her back. E3 discovered that R138 was saturated through her adult protective undergarment onto her bed clothes with urine. It was also revealed that R138 activated her call bell for assistance at 5:30 AM and waited for 90 minutes until E3 arrived at 6:50 AM, to be changed. E7 (Certified Nurse's Aide/CNA) was assigned to	F 353	D. (1) Weekly the NHA/designee will audit, and monitor that the D.O.N./designee and the scheduler met daily to discuss and adjust schedules accordingly (Attachment I). The NHA will calculate a compliance rate weekly that will be reported in monthly QA & A until 100% is achieved for 3 months, and ongoing as needed.	7/1/2014

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	085001	A. BUILDING _____ B. WING _____	C 05/08/2014

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F 353	Continued From page 24	F 353		

care for R138 as well as 21 other residents. According to the facility's investigation of this incident, E7 checked on R138 during the start of her shift. E7 did not check on the resident again or provide her with any care throughout the remainder of her shift until approximately 6:50 AM, when R138 was found by E3 to be saturated with urine.

On 5/6/14 at 8:30 AM, E18 (CNA) was interviewed. E18 worked on the same unit with E7 on 11/6/13 and stated there were normally 3 CNAs assigned to work, however, on 11/6/13, there were only 2 CNAs for 44 residents, most of whom were totally dependent on staff for care. E7 and E18 were each assigned to 22 residents.

On 5/6/14 at 9:00 AM, in a telephone interview with E15 (Licensed Practical Nurse), who worked as the 11-7 AM charge nurse in the unit on 11/6/13, she stated that nursing rounds are done every 2 hours at 11:30 PM, 2:00 AM and 4:00 AM. Additionally, CNAs are alerted when a call bell rings through their call bell pager and/or in a panel at the nursing station.

According to the facility's investigation of the incident, dated 11/7/13, confirmed that E7 did not check on the resident every two hours or provide her with any care throughout the remainder of her shift, until 6:50 AM. Additionally, E7 had her call bell pager in her pocket, but stated that she did not check it because she was busy.

During an interview with E3 on 5/6/14 at 9:30 AM, she stated that the charge nurse also monitors the call bell to alert the CNAs and it was possible that no one consistently monitored the call bell panel at all times.

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F 353	Continued From page 25 In an interview with E18 on 5/6/14 at 8:20 AM, she stated that no one had alerted her that R138's call bell light was ringing. During an interview with E17 (Maintenance Director) on 5/6/14 at 9:00 AM, he stated that according to his maintenance request list for November 2013, R138's call light was not included in the list for a non-functioning call bell. Findings were discussed with E2 (Director of Nursing) on 5/6/14 at 2:00 PM.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Paper towels were missing from one out of two kitchen hand sink dispensers, a dietary staff member handled the clean eating surfaces of forks and spoons with her bare hands and a floor fan was observed with dirty fan blades and	F 371	A. (1) Paper towels were restocked. (2) The Floor Fan was cleaned. (3) E10 was educated on the proper procedure for handling utensils. (4) The affected utensils were sanitized. B. All residents have the potential to be affected by this deficient practice. C. (1) The Staff Educator/Designee will educate the dietary staff on the proper procedure for handling utensils. (2) The Food Service Director (FSD) will conduct monthly kitchen sanitation audits. The audit will include floor fans, restocking of paper towels, and observations of staff food handling procedures (Attachment J). D. The results of the FSD monthly kitchen sanitation audits will be reported out in the monthly QA & A on an ongoing basis.	5/8/2014 7/7/2014 7/1/2014

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F 371	Continued From page 26 guards. Findings include: 1. Observation of the facility kitchen on 4/29/14 at approximately 7:45 AM revealed a lack of paper towels in one out of two dietary staff hand sink dispensers. The hand sink was located on the floor near the 3-compartment sink. E9 (Cook) confirmed this finding during an interview on 4/29/14 at 7:45 AM. 2. On 4/29/14 at 8:00 AM, a floor fan was observed with encrusted heavy dirt on the fan blades and guards. 3. On 4/29/14 at 11:25 AM, a dietary staff member (E10) was handling the eating surfaces of the clean forks and spoons for lunch with her bare hands. E9 confirmed the findings on 4/29/14 at approximately 11:25 AM.	F 371		
F 441 SS=D	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	F 441	A. (1) E19 was instructed on proper hand washing technique. (2) R92's oxygen tubing was covered immediately; R92 no longer resides in the facility. B. All residents have the potential to be affected by this deficient practice. C. (1) The Staff Educator/Designee will educate the licensed nurses and the C.N.A.'s on proper hand washing procedure with a return demonstration. (2) The Staff Educator will educate licensed nursing staff and C.N.A.'s on covering oxygen tubing when not in use. (3) The IDT will review the facilities infection control policies and will update according to the most current Standards of Practice (Policy/Procedure Attachment D). The Staff Developer/Designee will educate staff on the revisions of the policies.	5/8/2014 7/7/2014

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F 441	Continued From page 27 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 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility documentation, it was determined that the facility failed to ensure that their Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection was followed for 3 (R92, R93 and R143) out of 31 sampled residents. The facility failed to ensure staff practices were consistent with current infection control principles to prevent cross contamination by leaving R92's oxygen tubing uncovered and placed on top of her oxygen concentrator (device that provides oxygen). During the medication (med) pass	F 441	D. (1) Weekly the D.O.N./designee will audit 10 staff members for proper handing washing procedure (Attachment K). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as needed. (2) The D.O.N./designee will audit weekly 25% of residents that are on oxygen to monitor that tubing is covered while not in use (Attachment K). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months and as needed, and ongoing as needed.	7/1/2014

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F 441	Continued From page 28	F 441		

observation involving R93 and R143 on 5/1/14 the facility failed to ensure that handwashing was done as indicated and as per facility policy. Findings include:

The facility's Infection Control Policy and Procedure entitled "Hand Hygiene" (undated), stated, "... Hand hygiene consists of hand washing or use of alcohol gel... In the absence of a true emergency, personnel should ALWAYS perform hand hygiene: 1. BEFORE and AFTER resident contact... 5. AFTER situations during which... contamination of hands is like (sic) to occur, especially those involving contact with mucous membrane (includes mouth), blood or body fluids, secretions or excretions...".

1. During the med pass observation on 5/1/14 from approximately 8:50 AM to 9:35 AM, E19 (Licensed Practical Nurse) administered meds to R93 (9:05 AM) and R143 (9:30 AM) without any handwashing or sanitizing of her hands between residents. After completing meds for R143, E19 returned to the med cart to start getting meds ready for another resident still with no handwashing or sanitizing.

While in R143's room at approximately 9:30 AM, E19 picked up a napkin or tissue used by R143 to wipe her mouth- E19 picked up the tissue with her bare hands and threw it away. She did not wash her hands afterwards or sanitize them before returning to the med cart to prepare meds for another resident.

Findings were discussed and confirmed with E2 (Director of Nursing) during an interview on 5/2/14 at 2 PM.
2. Review of the facility's infection control policy

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F 441	Continued From page 29 entitled "Respiratory Therapy Equipment", dated 4/1/05, stated, "... Keep O2 (oxygen) tubing in a plastic bag when not in use ...". At approximately 12:00 PM on 5/6/14 R92's oxygen tubing was observed uncovered and placed on top of her oxygen concentrator. In an interview on 5/6/14 at 12:28 PM, E13 (Registered Nurse) confirmed that the oxygen tubing should be covered when not in use. Findings were reviewed with E2 (Director of Nursing) on 5/7/14 at 4:00 PM.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide or obtain laboratory services to meet the needs of its residents, including the timeliness of services for one (R51) out of 31 Stage 2 sampled residents. Findings include: R51 had a physician's order, dated 2/13/14 and timed 3:07 PM, that included blood tests for a basic metabolic panel (BMP) (set of eight tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balances) and a Keppra level (to determine therapeutic blood level of an anti seizure medication) to be drawn	F 502	A. R51's Keppra levels were drawn and the results were reported to the physician. B. All residents that have laboratory services ordered by the physician have the potential to be affected by this deficient practice. C. (1) The facility's "Laboratories Service" policy will be revised to indicate that the nurse taking the order for laboratory services will also be required to write the laboratory request slip so that the resident's blood work can be drawn(Policy/Procedure Attachment E). The Staff Developer/Designee will educate licensed nurses on the revised policy. (2) The D.O.N./designee will audit laboratory services for all residents to monitor that the blood work was drawn according to physician orders for the past 30 days. The physician will be notified accordingly.	5/8/2014 7/7/2014

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F 502	Continued From page 30 on 2/14/14. Review of R51's record, revealed that R51's blood drawn on 2/14/14 for the above tests was unusable and the blood tests were rescheduled to be drawn on 2/17/14. Record review revealed that on 2/17/14, only the BMP was redrawn. The facility failed to identify and obtain the Keppra level. Findings were discussed and confirmed during an interview with E2, Director of Nursing on 5/7/14 at 3:30 PM. E2 stated she ordered a STAT (immediate) lab request for the Keppra level. The facility failed to obtain laboratory services for R51 when a blood test for a Keppra level was not useable on 2/14/14 and it was to be redrawn on 2/17/14, but it was not done.	F 502	D. Weekly the D.O.N./designee will audit laboratory services to monitor that the blood work was drawn as ordered by the physician (Attachment L). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months and an ongoing basis as needed.	7/1/2014
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. This REQUIREMENT is not met as evidenced	F 514	A. (1) R107 and R162 are now being accurately recorded into the computer system directly from the worksheet. (2) E2 was educated on the need to record PO intake directly from the worksheet into the Sigmacare computer system. B. All resident that have a diet order for PO (by mouth) have the potential to be affected by this deficient practice. C. (1) The facility's" Meal Intake" policy will be revised to indicate that meal percentages need to be recorded directly from the worksheet into the Sigmacare computer system.	5/8/2014 7/7/2014

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F 514	Continued From page 31 by: Based on record reviews and review of other facility documentation, it was determined that the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for two (R107 and R162) out of 31 Stage 2 sampled residents. Findings include: 1. Review of the facility's policy (undated) entitled "Meal Intake" stated, "... 1. Nursing staff will record the estimated percentages related to each resident's meal intake at the end of each meal ... 4. Residents and family are instructed on the importance of reporting meal intake to the Nursing Department". R107 was care planned for "Risk for Weight Loss" on 12/17/13. One approach included to record the percentage of each meal eaten. Review of the Certified Nurse's Aide (CNA) Documentation Record for the months of March and April 2014 revealed the absence of R107's meal intakes for the following days: - 3/2/14 lunch and dinner; - 3/8/14 breakfast and lunch; - 3/11/14 breakfast and lunch; - 3/12/14 breakfast and lunch; - 3/16/14 breakfast and lunch; - 3/17/14 breakfast and lunch; - 3/29/14 dinner; - 4/16/14 lunch; - 4/22/14 lunch; and - 4/24/14 breakfast and lunch. Findings were reviewed with E2 (Director of Nursing) on 5/7/14 at 4:00 PM. Although E2 stated that R107's family took her out of the	F 514	(2) The policy will also be revised to instruct staff to write a "0" for meal percentage when the resident is out on Leave of Absence (LOA). Additionally, nurse will be instructed to write a progress note indicating when a resident is on LOA (Policy/Procedure Attachment F). (3) The Staff Developer/Designee will educate licensed nurses and C.N.A.'s on the revised policy. D. (1) Weekly the Unit Manager/designee will conduct meal round audits to monitor that meal intakes are being recorded accurately and are inputted into the computer directly from worksheets (Attachment M). The compliance rate of the weekly audits will be reported in QA & A until 100% is achieved for 3 months and ongoing as needed. (2) Weekly the D.O.N./designee will audit that progress notes were written for residents that were out on LOA and that their meal intakes are being recorded a "0" for the meals they were gone (Attachment M). The compliance rate of weekly audits will be reported in QA & A until 100% is achieved for 3 months, and ongoing as need.	7/1/2014

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F 514	Continued From page 32	F 514		

facility to eat occasionally, review of the nurse's progress notes for the above listed dates lacked evidence of these outings.

2. R162 was care planned for "Nutritional Status: Risk for Weight Loss..." on 4/30/14. One approach included to record the percentage of the food eaten at meals.

On 5/5/14 at 8:37 AM, R162 was observed by two surveyors to have consumed 100% of her breakfast.

On 5/6/14 at 10 AM, review of R162's breakfast meal percentage on 5/5/14 revealed it was incorrectly documented as 50% by E14 (Certified Nurse's Aide/CNA).

During an interview on 5/6/14 at 10:05 AM, E14 was informed that two surveyors observed R162 consume 100% of her breakfast on 5/5/14. E14 was asked to explain why she incorrectly documented R162's meal consumption as 50%. E14 stated that she documented R162's meal consumption from memory and not from the sheet on the clipboard where it was originally recorded. E14 confirmed the finding.

Findings were discussed with E2 (Director of Nursing) on 5/6/14 at 10:10 AM. E2 stated the CNAs were supposed to document the resident's meal intakes on a clipboard in the dining room and then the data was later recorded in the computer. After it was recorded in the computer, the original documentation from the clipboard was shredded.

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F 514	Continued From page 33 The facility failed to ensure that R162's meal intake on 5/5/14 at breakfast was accurately documented.	F 514		

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

DATE SURVEY COMPLETED: May 8, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from April 29, 2014 through May 8, 2014. 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 100. The Stage 2 survey sample size was 31.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 5/8/14, F157, F159, F225,	Cross Reference CMS 2567 F157, F159, F225

Provider's Signature Eileen Mahler Title Administrator Date 6/3/14

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

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3 Mill Road, Suite 308
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NAME OF FACILITY: Kentmere DATE SURVEY COMPLETED: May 8, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F241, F272, F309, F334, F353, F371, F441, F502 and F514.	Cross Reference CMS 2567 F241, F272, F309, F334, F353, F371, F441, F502, and F514
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections 4-904.11 (A) (B), 6-301.12 and 6-501.12 (A).	
4-904.11	**Kitchenware and Tableware.** **(A) SINGLE-SERVICE and SINGLE-USE ARTICLES and cleaned and SANITIZED UTENSILS shall be handled, displayed, and dispensed so that contamination of FOOD- and lip-contact surfaces is prevented.** **(B) Knives, forks, and spoons that are not pre-wrapped shall be presented so that only the handles are touched by EMPLOYEES and by CONSUMERS if CONSUMER self-service is provided.** This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed 5/8/14, F371, example 3.	Cross Reference CMS 2567 F371
6-301.12	Hand Drying Provision. Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with: 1. (A) Individual, disposable	

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

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NAME OF FACILITY: Kentmere DATE SURVEY COMPLETED: May 8, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	towels; **2. (B) A continuous towel system that supplies the user with a clean towel; or** **3. (C) A heated-air hand drying device; or** **4. (D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 5/8/2014, F371, example 1.	Cross Reference CMS 2567 F371
6-501.12	**Cleaning, Frequency and Restrictions.** **(A) Physical facilities shall be cleaned as often as necessary to keep them clean.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 5/8/2014, F371, example 2.	Cross Reference CMS 2567 F371