

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

PRINTED: 04/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Revised Report following IDR held on 4/25/14, F309 example #1 disputed. Scope and severity to F309 unchanged but text changes made to the tag.</p> <p>An unannounced complaint survey was conducted at this facility from February 20 through March 5, 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 156. The survey sample was six which included (5) five active residents and (1) one closed record.</p>	F 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>	4/19/14
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p>	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *May Colleen Ruff* TITLE: *MHA* (X6) DATE: *5/16/14*

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has provided 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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IDENTIFICATION OF DEFICIENCIES NARRATIVE OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2014
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157	<p>Continued From page 1</p> <p>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 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R2) out of six sampled residents, the facility failed to immediately consult with the doctor when there was a significant change in the resident's physical status. Findings include:</p> <p>On 2/1/14 at 12:21 PM, R2's progress note stated, "... Noted with a 9 cm (centimeter, 1 centimeter = 0.39 inches) x (by) 11 cm semi hard swelling to her upper right chest wall extending under her right armpit. Resident c/o (complained of) pain when area is touched. No redness, warmth, or bruising noted. Call put out to MD (doctor)".</p> <p>On 2/1/14 at 12:45 PM, R2's doctor returned the call and ordered x-rays of the right ribs and chest.</p> <p>On 2/1/14 at 6:12 PM, R2's progress note stated that the x-ray results came back with no abnormalities seen in the right ribs but the right lung had findings that were compatible with</p>	F 157	<p>157</p> <p>Notify of Changes (Injury/Decline/Room, etc). It is the practice of the facility to immediately inform the resident, consult with the resident's physician; and if known, notify the residents 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,</p>	4/19/14
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F 157 Continued From page 2

pneumonia. The doctor was called and made aware of the x-ray results and ordered to start a new antibiotic, Levaquin, daily for seven days and to discontinue the current antibiotic, Keflex.

Review of the progress note, dated 2/2/14 at 3:16 AM, revealed a late entry for 2/1/14 at 6:12 PM that stated, "Resident noted with bruising under right breast of about 10 cm by 5 cm. No warmth, but tender when touched. MD made aware, new order to make a note for patient to be seen on Monday" (2/3/14). There was no evidence in the progress notes that the facility informed R2's doctor on 2/1/14 at 6:12 PM that R2 had blood clots in both legs and was on Lovenox (a type of heparin/anticoagulant/blood thinner medication used to treat blood clots). Additionally, there was no evidence that the facility reported to R2's doctor the status of the swelling/bruising prior to giving the resident Lovenox, to obtain clarification regarding whether to administer Lovenox on 2/1/14 at 8 PM and to provide the opportunity for the doctor to give further orders as indicated that evening.

Additional progress notes included: 2/2/14 at 4:57 AM, stated, "C/o (complaining of) pain, facial grimace noted when rt (right) arm is touched"; 2/2/14 at 6:48 AM, stated, "Swelling to pt's (patient's) right breast is noted to have increased bruising and swelling. The area now measured 45 cm by 22 cm, while bruising to left is 10 by 6 cm. Medicated x1 (once) for pain. Pt is currently resting comfortable in bed"; 2/2/14 at 8:01 AM, stated, "Pt. was picked up by ambulance at 0800 AM. Family is aware".

On 3/4/14 at 2:01 PM, in a telephone interview, E7 (Licensed Practical Nurse/LPN) stated that on

F 157

or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life threatening conditions of clinical complications): a need to alter treatment significantly (i.e. 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).

Resident R 2 no longer resides in the facility.

The Administrative Director of Nursing Services/ADNS and or Designee will audit the residents with bruising, swelling and on Lovenox for physician notification. Attachment #1

The Staff Development Coordinator or Designee will in service the nursing staff on notification of physician when bruising and swelling noted and patient on Lovenox.

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F 157	<p>Continued From page 3</p> <p>2/1/14 at 6:12 PM she, "Called her (referring to the on call doctor for R2) about the x-ray results and the swelling that I was told about when I came onto the shift. I told her (referring to the on call doctor) she (referring to the resident) was on Keflex when she gave the order for Levaquin and I asked her if she wanted the Keflex continued or discontinued. She told me to discontinue the Keflex. It was just about the antibiotics, I did not tell the covering doctor about any of the resident's other medications including Lovenox. I told the covering doctor that there was bruising under the right breast. The on call doctor told me to make a note for the regular doctor to see the resident on Monday (2/3/14)."</p> <p>On 3/4/14 at 3:40 PM, in an interview, E8 (Registered Nurse) stated that she got report on 2/1/14 from E7 who also worked a double 3 to 11 and 11 to 7 shifts. E8 stated that she had R2 as part of her assignment for the 11 to 7 shift. E8 stated, "I go at the beginning of the shift. I think to give her medicine, there was no grimacing at that time. I did look at the area but did not measure it". E8 stated that on 2/2/14 about 4:57 AM that the CNA (Certified Nurse's Aide) told her that the resident had facial grimacing when she was turned and repositioned so, "I gave her Oxycodone (narcotic pain reliever) for pain. She had facial grimacing noted when her right arm was touched. Even though I did not document it, I saw that the right breast and under the right armpit had increased in size but I did not measure it. It was bruised, purple blue in color. At 6:48 AM, the size had increased more from earlier with bruising and I measured it. Then, I said we have to send her out, called the nurse supervisor and called the doctor".</p>	F 157	<p>The Administrative Director of Nursing Services and or Designee will do weekly audits of residents who have bruising and or swelling and are on Lovenox to evaluate the notification of physician until 100% compliance for 3 consecutive evaluations.</p> <p>Then monitor weekly until we reach 100% success over 3 consecutive evaluations.</p> <p>Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.</p> <p>Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans</p> <p style="text-align: right;">4/9/14</p>

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F 157	Continued From page 4 The facility failed to notify R2's physician on 2/1/14 regarding the status of the swelling and bruising of the right chest wall and breast, failed to call the doctor regarding the administration of Lovenox to the resident to obtain clarification and other orders as indicated. The facility also failed to notify R2's doctor on 2/2/14 with a change in condition overnight with increased swelling and bruising to R2's right breast and under the armpit which were observed at 4.57 AM. R2's physician was not contacted until 6.48 AM and the resident was sent to the hospital at 8 AM and subsequently admitted requiring blood transfusions (Receive blood through an intravenous (IV) line inserted into one of your blood vessels. Blood transfusions are used to replace blood lost during surgery or a serious injury.)	F 157	F225 – Investigate/Report Allegations/Individuals It is the practice of the facility 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.
F 225 SS=E	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	It is the practice of the facility to maintain evidence that all alleged violations are thoroughly investigated and the practice of the facility to prevent further potential abuse while the investigations are in process.

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F 225 Continued From page 5
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 interview, record review and review of facility documents as indicated, it was determined that the facility failed to immediately report and thoroughly investigate allegations that had the potential for abuse or neglect of care for three (R1, R2 and R3) out of six (6) sampled residents. For R1, the facility failed to immediately report to the state when R1 had her fingernails trimmed on 12/30/13 by facility staff and 8 out of 10 fingers were cut and bleeding. For R2, the facility failed to immediately report to the state an injury of unknown origin when R2 had swelling and bruising on 2/1/14. For R3, the facility failed to complete a 5 day follow up incident report to the state when the resident had a serious injury reported on 1/22/14. Findings include:

F 225 It is the practice of the facility to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident and if the alleged violation is verified appropriate corrective action is taken.

Resident R 2 no longer resides in the facility.

R1 and R3 initial incident and 5 day follow up was sent to the state.

The Administrative Director of Nursing Services and or Designee will do random audits of reportable incidents to evaluate the timely reporting and 5 day follow-up to DLTC.

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F 225	<p>Continued From page 6</p> <p>On 2/24/14 at approximately 3 PM, the surveyor requested the facility's policy and procedure for abuse/neglect and was provided with a booklet entitled, "Patient Protection Practice Guide", issued on 11/2011, that stated, "The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, ... are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency) ... The results of all investigations must be reported to the administrator or his/her 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."</p> <p>Cross refer F312</p> <p>1. The facility's incident report for R1, dated 12/31/13 at 11:16 AM, stated, "Incident Date/Time 12/30/2013 at 9:30 PM; Incident Type: Injuries; ...Aide (E17, Certified Nurse's Aide) was asked by nurse to cut resident's finger nails. Aide cut resident's fingers nails then noticed one of her finger tips to be bleeding ... When aide and nurse went back to resident, 8 of 10 fingers then noted to be bleeding at finger tips ...".</p> <p>On 2/27/14 at 11:45 AM, in an interview, E5 (Licensed Practical Nurse/LPN/Unit Director) stated that the staff did not know to report the incident on 12/30/13 and that she reported it the next morning. E5 further stated that she verbally spoke with all the staff instructing them about reporting incidents at the time.</p> <p>The facility failed to identify this incident as a potential for abuse/neglect of care and services</p>	F 225	<p>The Staff Development Coordinator and or Designee will in-service nursing staff on:</p> <ul style="list-style-type: none"> identifying and reporting incidents of potential abuse/neglect of care and services identifying and reporting Incidents of injury/unknown source Reporting these incidents timely to the Division of Long Term Care and Resident Protection and timely 5 day follow-up All reportable incidents will go through morning and afternoon meeting to monitor they are reported timely and the 5 day follow up is completed timely. 	4/19/14

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F 225 Continued From page 7
and failed to immediately report it to the state. On 2/27/14 at 11:45 AM, E5 confirmed the findings

Cross refer F309, example 1A
2. The facility sent in two incident reports for R2 as follows:
- The incident report, dated 2/2/14 at 1:03 PM, stated, "Date/Time: 2/2/14, 7 AM; Incident type: Other, Unknown Source; Description of Incident: Reported to shift this morning and night nurse notified me that patient had bruising and swelling to the right side of her ribs which had increased within the last 24 hrs (hours). Pt. (patient) was first noted with swelling on her right side above the breast yesterday and X-ray was done. I went to room to assess patient and noted patient with major bruising and more towards the right side and swelling. MD (doctor) notified and patient sent to (name of hospital) emergency room."
- The incident report, dated 2/3/14 at 11:41 AM stated, "Date/Time: 2/1/14, 12:21 PM; Incident type: Injuries; Description of Incident: The patient was noted by the nurse with bruising to right upper chest wall extending to her armpit area. The bruising was noted on 2/2/14 as getting larger and was also noted to the pts (patient's) left side breast area..."

The facility failed to immediately report to the state on 2/1/14 an injury/ unknown source. The incident was not reported until 2/2/14 and 2/3/14 after R2 was hospitalized. On 3/4/14 at 4:10 PM, findings were confirmed by E4 (Registered Nurse, Director of Care Delivery).

3. According to R3's incident report, dated 1/22/14 at 12:09 AM, the report stated, "Date/Time: 1/21/14, 7PM; Incident type: Fall;

F 225 The Administrative Director of Nursing Services and or designee will do random daily audits of reportable incident reports to monitor timely submission of incidents and 5 day follow up to The DLTC/State.

The Administrative Director of Nursing Services and or designee will evaluate

This will be done until 100% compliance is reached for 3 consecutive evaluations. Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

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F 225 Continued From page 8
Injury Level: Serious Injury; Description of Incident: Resident was witness (sic) walking down the hallway, tripped over her feet and fell on her back hit her head. She sustained laceration to head and was sent to ER (emergency room) for eval. (evaluation)"

F 225 Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans

F 280 SS=D 483.20(d)(3), 483 10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280
F280 Right to Participate Planning Care – Revised CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

It is the facility practice to have a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, an RN with responsibility for the resident and other appropriate staff in disciplines as determined by the residents needs and to the extent practicable, the participation of the resident, the resident's family or legal representative; and periodically reviewed by a team, of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

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F 280 Continued From page 9

Based on observation, interview and record review, it was determined that the facility failed to review and revise a care plan for one (R5) out of six sampled residents. Findings include:

Cross refer F309 example 2

Review of R5's care plan entitled, "ADL (activities of daily living) Self care deficit related to limited mobility (ability to move freely and easily), dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) and syncope (fainting)", initiated 4/2/13 and last revised on 8/7/13, had the goal of will receive assistance necessary to meet ADL needs with a target date of 5/21/14. Interventions included: "Restorative ambulation. Ambulate 300 feet with rolling walker and close supervision 2 x (times) day..."

On 1/14/14, upon completion of Physical Therapy services. R5's doctor ordered a Restorative Nursing Program [(RNP) restorative nursing interventions promote the resident's ability to adapt and adjust to living as independently and safely as possible] for R5 to ambulate with a single point cane, contact guard assistance (Have one or two hands on the person's body to help with balance.) for 200 feet 5 times per week

Review of the computerized Certified Nurse's Aide/CNA documentation from 1/15/14 through 2/24/14 revealed that R5 was incorrectly being ambulated with a roller walker and close supervision twice a day rather than a single point cane as per R5's doctor's order.

On 2/24/14 at 1:10 PM, an observation was made

F 280 R5 care plan was reviewed and revised and updated to reflect R5 current Restorative Nursing Program.

The Administrative Director of Nursing Services and or designee will audit resident's currently on a restorative program to monitor the Activities of Daily care plan is reflecting the current Restorative Nursing Program.

The Staff Development Coordinator and or designee will in-service nursing staff on Restorative program process, revising Activities of Daily Living care plans to reflect current Restorative Nursing Program.

All restorative nursing programs will go through EAGLE ROOM (the morning and afternoon meeting) to monitor these programs are implemented and the Activities of Daily Living care plan is current to Restorative Nursing Program.

4/19/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK	STREET ADDRESS CITY STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808
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F 309 Continued From page 11
wall, for a Lovenox (blood thinning medication) dependent resident. Additionally, for R2, the facility failed to follow the plan of care and failed to correctly transcribe a medication order leading to a failure to administer the number of doses of the medication ordered by the physician. For R5, the facility failed to follow the plan of care when the doctor's order of 1/14/14 for the restorative nursing program was not implemented. Findings include:

According to Mosby's 2013 Nursing Drug Reference, used by the facility, Lovenox is an anticoagulant (blood thinner) and antithrombotic (reduces blood clots). Nursing considerations included to assess for bleeding and to report any signs of bleeding: gums, under skin, urine and stools (bowel movements).

The manufacturer's package insert for Lovenox stated, "Geriatric Use... treatment of Deep Vein Thrombosis (DVT/blood clots) ... The incidence of bleeding complications was higher in geriatric patients as compared to younger patients when Enoxaparin sodium (Lovenox) injection was administered at doses of 1.5 mg (milligrams)/kg (kilogram = 2.2 pounds) once a day or 1 mg/kg every 12 hours". Also according to manufacturer's recommendations, Lovenox should not be used in patients who are actively bleeding or who have a low count of blood cells called platelets, which aid in clotting. Lovenox must be used with care in patients who have kidney problems and excessive bleeding.

1A. R2 was admitted to the facility on 12/24/13 from the hospital where the resident had been treated for fainting, a rapid heartbeat, a urinary tract infection, kidney failure, and acute and

F 309 **F309 Provide Care/Services for highest well being**

It is the facility practice to provide 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.

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1 A. R2 no longer resides in the facility.

The Administrative Director of Nursing Services and or designee will audit residents on Lovenox to:

- assess/monitor and identify if resident has any bruising and or swelling

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F 309	Continued From page 12	F 309	<ul style="list-style-type: none"> The doctor is notified resident is on Lovenox when called so nurse can obtain clarification whether to administer the Lovenox During audit if resident is identified to have any bruising or swelling evaluate the nurses are observing and assessing the areas <p>The Staff Development Coordinator and or designee will in service the nursing staff to:</p> <ul style="list-style-type: none"> Assess/ monitor and identify residents on Lovenox for swelling and bruising Notify doctor if resident is on Lovenox 	4/19/14
	<p>chronic back pain with a sacral fracture (a break in the triangle-shaped bone that is found at the bottom of the spine). R2 also had dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning).</p> <p>The following documentation was contained in the clinical record, facility documents and hospital record:</p> <p>12/24/13 - Admission Assessment indicated that R2 was a fall risk due to a history of falls, weakness, unsteadiness. the resident was on scheduled pain medication and had bruising on both lower legs and three skin tears.</p> <p>12/24/13 - Care plan entitled, "At risk for falls due to impaired balance/poor coordination, unsteady gait, history of falls and potential medication side effect", initiated on 12/24/13 and last revised on 1/28/14, with a goal to minimize the risk for falls. Interventions included: Administer medications per doctor 's orders; Encourage to transfer and change positions slowly; Low bed; Provide assist to transfer and ambulate as needed; Reinforce need to call for assistance; Report development of pain, bruises, change in mental status ADL (activities of daily living) function ... per facility guidelines after a fall; Obtain urinalysis with culture and sensitivity to rule out a UTI (urinary tract infection); Therapy evaluation and treatment per orders.</p> <p>12/31/13 - The admission Minimum Data Set Assessment (MDS) stated that R2's mental functions were severely impaired, required extensive assistance of two persons for bed mobility and transfers. did not walk in the room or</p>			

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in the hallway and was dependent with assistance of one person for locomotion on and off the unit. The fall history was unable to be obtained but the resident had no falls since admission. This MDS stated that the resident weighed 169 pounds.

1/8/14 - A facility incident report, timed 8:43 PM, revealed that R2 had an unwitnessed fall. According to the investigation report, dated 1/8/14 at 8:45 PM, "Patient found lying on the floor on her right side with the wheelchair beside her on its side in the hallway ... No injuries noted at this time, positive movement of all extremities (arms and legs) with mild pain to right arm ..."

1/27/14 - The progress note at 2:30 PM stated that R2 was noted with swelling, warmth and pain to the right knee. R2's doctor/nurse practitioner was notified and orders were given for an x-ray of the right knee, an ultrasound of both legs and laboratory (lab) tests.

1/27/14 - The ultrasound report of the legs revealed that both legs had non-occluding (not totally blocking the blood flow of the vein) deep venous thromboses (DVTs/blood clots).

1/27/14 - R2's doctor ordered Lovenox solution 80 mg (milligrams) to be administered via a needle every twelve hours to treat R2's blood clots. Review of the eMAR (computerized Medication Administration Record) revealed that R2 received Lovenox 80 mg by injection at 8 PM.

1/28/14 - The lab results revealed the following:
- High white blood cell (help fight infections) count of 14.3 (normal = 3.8 -10.8);
- Low red blood cell (deliver oxygen throughout

F 309

- if residents have bruising and swelling monitor bruising and swelling. All residents identified on Lovenox that have a bruise will be tracked in the EAGLE Room (morning and afternoon meeting) to identify the facility is assessing and monitoring the bruised area and have notified the doctor.

The Administrative Director of Nursing Services and or designee will monitor daily to evaluate that patients on Lovenox are being:

- assessed/monitored and identified if any significant change in bruising and or swelling
- The doctor is notified resident is on Lovenox when called so nurse can obtain clarification whether to administer the Lovenox

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F 309 Continued From page 14
the body) count of 2.97 (normal = 3.8-5.10);
- Low hemoglobin (a protein in red blood cells that carries oxygen) count of 9.2 (normal = 11.7 - 15.5);
- High blood urea nitrogen (nitrogen in the blood which indicates how well the kidneys are functioning) of 30 (normal 7 - 25);
- High creatinine (creatinine in the blood which indicates how well the kidneys are functioning) of 1.12 (normal = 0.60 - 0.88); and
- High uric acid (a natural breakdown of the body's cells and food eaten) level of 9 (normal range = 2.5 - 7).
The last three lab results indicate that kidney function had decreased.

1/28/14 - A care plan entitled, "Anticoagulant therapy to treat BLE LE DVT (bilateral lower extremity deep vein thrombosis - blood clots in both legs); at risk for adverse effects", had the goal that R2 will have no adverse effects. Interventions included: Administer per physician orders; Obtain labs as ordered and notify doctor of results; Report adverse effects such as blood in urine/stool, gums/nose bleeding, bruising.

1/28/14 - A facility incident report, timed 9 PM, revealed that the resident was found on the floor in a supine position (lying face up) with her legs stretched out and the wheelchair behind her. A head to toe assessment was done with no injuries found.

1/28/14 - 1/31/14 - Review of the 1/2014 eMAR revealed that R2 received Lovenox 80 mg by injection at 8 AM and 8 PM from 1/28/14 through 1/31/14.

2/1/14 - Review of the 2/2014 eMAR

F 309 • During audit if resident is identified to have any bruising or swelling evaluate the nurses are observing and assessing the areas
• All residents identified on Lovenox that have a bruise will be tracked in the EAGLE Room (Morning and afternoon meeting) to identify the facility is assessing and monitoring the bruised area and have notified the doctor.

This will be done until 100% compliance is reached for 3 consecutive evaluations.
Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

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(computerized Medication Administration Record) revealed that R2 received Lovenox 80 mg by injection at 8 AM on 2/1/14.

2/1/14 - The progress note at 12:21 PM, stated, "... Noted with a 9 cm (centimeter) x (by) 11 cm semi hard swelling to her upper right chest wall extending under her right armpit. Resident c/o (complained of) pain when area is touched. No redness, warmth, or bruising noted. Call put out to MD (doctor)".

2/1/14 - The doctor returned the call at 12:45 PM. R2's doctor ordered x-rays of the right ribs and chest.

2/1/14 - Review of the 2/2014 eTar (computerized Treatment Administration Record) revealed that R2 had a body audit done at 2:45 PM, noted by a checkmark. However, this body audit was incomplete. On 2/1/14 at 12:21 PM, R2 was observed with a 9 cm by 11 cm semi hard swelling to her upper right chest wall extending under her right armpit. Despite doing a body audit at 2:45 PM, there was a lack of evidence in R2's record that the right chest wall and armpit areas were assessed and measured.

2/1/14 - The progress note at 6:12 PM stated that the x-ray results came back with no abnormalities seen in the right ribs but the right lung had findings that were compatible with pneumonia. The on-call doctor was called, made aware of the of the x-ray results and ordered an antibiotic.

2/2/14 - A progress note at 3:16 AM, revealed a late entry for 2/1/14 at 6:12 PM that stated, "Resident noted with bruising under right breast

F 309

Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans

1B. R2 no longer resides in the facility.

The Administrative Director of Nursing Services and or designee will audit residents on Nystatin to evaluate the residents care plan is being followed and the Nystatin is administered per doctors order.

The Staff Development Coordinator and or designee will in service the nursing staff when resident is on Nystatin (and/or any other medications) if not available per doctor's order notify doctor and if doctor still wants medication order call the pharmacy to request that the back-up pharmacy deliver the medication.

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F 309	<p>Continued From page 16</p> <p>of about 10 cm by 5 cm. No warmth, but tender when touched. MD (doctor) made aware, new order to make a note for patient to be seen on Monday (2/3/14)". There is no evidence that in the presence of swelling and bruising to the right chest wall that the doctor was notified that R2 was on Lovenox. There is also no evidence that the right chest wall was assessed with measurement between the hours of 12:21 PM and 6:12 PM (almost 6 hours) during which the area went from a 9 centimeters [cm] by 11 cm swelling to then include a 10 cm by 5 cm bruising.</p> <p>2/1/14 - Review of the 2/2014 eMAR (computerized Medication Administration Record) revealed that R2 received Lovenox 80 mg by injection at 8 PM. There was no evidence that the doctor was called prior to the administration of Lovenox despite the presence of swelling and bruising to the right chest wall.</p> <p>2/2/14 - A progress note at 4:57 AM, stated, "C/o (complaining of) pain, facial grimace noted when rt (right) arm is touched". There is no evidence that the swelling and bruising on the right chest wall was reassessed at this time.</p> <p>2/2/14 - A progress note at 6:48 AM, stated, "Swelling to pt's (patient's) right breast is noted to have increased bruising and swelling. The area now measured 45 cm by 22 cm, while bruising to left is 10 by 6 cm. Medicated x1 (once) for pain. Pt is currently resting comfortable in bed." This was the first assessment and measurement of the bruising in more than 12 hours and showed an increase in size on the right chest wall from 10 cm by 5 cm to 45 cm by 22 cm with progression to the left chest wall.</p>	F 309	<p>The Administrative Director of Nursing Services and or designee will monitor weekly residents on Nystatin to evaluate the residents plan of care is followed and administered per doctor's order</p> <p>This will be done until 100% compliance is reached for 3 consecutive evaluations.</p> <p>Then monitor weekly until we reach 100% success over 3 consecutive evaluations.</p> <p>Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.</p> <p>Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans</p>

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F 309	<p>Continued From page 17</p> <p>2/2/14 - A progress note at 8:01 AM, stated, "Pt. was picked up by ambulance at 0800 AM. Family is aware"</p> <p>2/2/14 - The hospital CT scan (Computerized Tomography/CAT scan - an x-ray procedure) of the chest showed, "Findings: Small to moderate sized bilateral (both sides) simple pleural effusions (a condition in which excess fluid builds around the lung), right somewhat greater than left ...Large right ...chest wall ...with subacute hematomas (a less than acute localized swelling filled with blood) The anterior (front) chest wall component measures 8.6 x 14.1 x 15.1 cm in size. Right lateral/axillary (armpit area) component measures 6.1 x 11.4 x 10.0 cm in size ... Structures of the chest reveal subacute fractures (broken bones) of the 11th, 10th, 9th, 8th, and 7th right ribs ... subacute fracture of the right 3rd rib anteriorly is also noted. Impression: 1. Two large right chest wall subacute hematomas surrounded by substantial chest wall edema (swelling) ...2. Multiple subacute right rib fractures. 3. Moderate sized bilateral pleural effusions."</p> <p>2/2/14 - The hospital History and Physical for R2, dictated at 11:03 AM, stated that the resident presented, "... To the emergency room with right chest wall swelling ... She fell out of her wheelchair on Tuesday ... It has gotten markedly worse over the past 24 hours and now she has a bulging hematoma over her right breast. She was brought into the emergency room with a blood pressure 81/47 (normal = 120/80). She was found to have a hemoglobin of 5.9. CAT scan showed a right sided chest wall hematoma with multiple rib fractures ...Right chest wall hematoma in the setting of recent fall and recent initiation of</p>	F 309	<p>2. R5 care plan was reviewed and revised and updated to reflect R5 current Restorative Nursing Program.</p> <p>The Administrative Director of Nursing Services and or designee will audit resident's currently on a restorative program to monitor the Activities of Daily Living care plan is reflecting the current Restorative Nursing Program.</p> <p>The Staff Development Coordinator and or designee will in-service nursing staff on Restorative program process and revising Activities of Daily Living care plans to reflect current Restorative Nursing Program. All restorative programs will go through the morning and afternoon meeting to monitor these programs are implemented and the Activities of Daily Living care plan is current to Restorative Nursing Program.</p> <p>The Administrative Director of Nursing Services and or designee will monitor daily the Restorative</p> <p style="text-align: right;">4/19/14</p>

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F 309	<p>Continued From page 18</p> <p>anticoagulation (blood thinner) ... We will complete the blood transfusions...". The resident's hemoglobin when last tested in the facility on 1/28/14 was low at 9.2 but had decreased to 5.9 on arriving at the hospital.</p> <p>2/2/14 - The "Forensic Nurse Examiner Elder Physical Abuse And Neglect Forensic Evaluation", at 12:45 PM, stated that a full examination was done and information was obtained from the facility and from R2's family. Under the assessment of abuse patterns it stated, "... Physical other (checked) 'Pt c (patient with) bruising + (and) ribs fx (fractures) noted upon assessment, unk (unknown) hx (history) of events'". Under "current level of pain based on the 'Wong Baker pain faces scale' was circled 5-6, hurts even more with location of pain R (right) chest". Types of findings were in a diagram as follows: "1. (referring to front chest wall) BR (bruise) described as large area of bruising, dark blue, purple in color, Pt. c/c (patient complaining of) tenderness, large area of swelling noted, cont (continuing) to side; 2. (referring to left arm) BR - smaller bruise red to blue in color; 3. (referring to left arm) ST (skin tear) bruise red to blue in color, 0 (no) active bleeding; 4. (referring to abrasion [scraped area] left elbow) abrasion c (with) scabbing noted to elbow; 5. (referring to right front arm area) BR - areas of bruising blue to dark purple noted to R (right) arm; 7. (referring to left ear) BR - bruise blue to purple in color to ear ..."</p> <p>2/11/14 - The facility's doctor for R2 wrote a post discharge note that stated, "Pt was sent from (name of facility) to (name of hospital) where she was found to have multiple 'subacute' rib fractures on CT. Interestingly those were not seen on CXR (chest x-ray) here or at (name of</p>	F 309	<p>Nursing Program to evaluate it reflects the current Activities of Daily Living care plan.</p> <p>This will be done until 100% compliance is reached for 3 consecutive evaluations. Then monitor weekly until we reach 100% success over 3 consecutive evaluations.</p> <p>Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.</p> <p>Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans</p> <p style="text-align: right;">4/19/14</p>

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F 309	Continued From page 19 the hospital). I do not know when these occurred: Conceivably they could have happened in December with her syncopal (fainting) event or when she fell here (referring to when R2 fell twice while she was a resident at the facility). The late bruising undoubtedly was worsened by her Lovenox anticoagulation". 3/4/14 - At 1:30 PM, in an interview, E13 (Certified Nurse's Aide/CNA) stated that R2 could stand and was transferred with two people at times. E13 stated that she did not remember using any lift to transfer the resident. E13 reviewed her statement from an interview on 2/2/14 and stated that the incident was 2/1/14 not 2/2/14 as per the written statement. E13 stated that her statement was accurate and after dinner when she cared for the resident that she noticed that the right breast was very swollen and bruised and called the nurse to show it to her. 3/4/14 - At 1:45 PM, in an interview, E14, (CNA) stated that on 1/31/14, 7 - 3 shift he used the stand-up lift with another CNA to transfer the resident. E14 stated, "One person stayed with the resident while the other CNA operated the stand-up lift... the resident did not complain of pain, moan at any time during the transfer or during the dayshift". E14 stated that after the stand-up lift was used to transfer the resident to the toilet and back into the wheelchair, R2 was wheeled into the dining room for breakfast. E14 further stated that later R2 was able to pivot transfer with one person assistance to the toilet and to the wheelchair. 3/4/14 - At 2:01 PM, in a telephone interview, E7 (Licensed Practical Nurse/LPN) stated that on 2/1/14 at 6:12 PM she, "Called her (referring to	F 309		4/19/14

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the on call doctor for R2) about the x-ray results and the swelling that I was told about when I came onto the shift...It was just about the antibiotics, I did not tell the covering doctor about any of the resident's other medications, including Lovenox. I told the covering doctor that there was bruising under the right breast. The on call doctor told me to make a note for the regular doctor to see the resident on Monday" (2/3/14).

3/4/14 - At 2:30 PM, in an interview, E15 (LPN) after reviewing her progress note for R2 on 2/1/14 at 12:21 PM, stated, "The resident had a semi hard swelling on her right upper chest that extended to the right armpit. The area was not warm, discolored or bruised. It measured 9 cm by 11 cm and the resident complained of pain when the area was touched... I called the doctor and he ordered x-rays of the right ribs and chest. 12:21 PM was the first that the right rib/armpit swelling was identified". E15 further stated that she cared for R2 on 1/31/14 and with regards to the right rib and armpit swelling, "It was not there on 1/31/14".

3/4/14 - At 3:25 PM, in an interview, E12 (LPN) after reviewing the nurse's note and witness statement she wrote after R2's fall on 1/28/14 at 9 PM, stated that the resident was offered to go to bed but the resident did not want to go to bed. The resident wanted to go home and she was seated in her wheelchair by the nurses' station. E12 stated that she went down the hallway to give another resident medication and a few minutes later she found the resident on the floor lying on her back with the wheelchair behind her. E12 further stated, "I did a head to toe assessment, asked the resident to move her arms, legs, did neuro checks (neurological checks used to check for injury or issues with the brain) and vital signs. I

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found no injuries. I asked the resident if she would agree to go to bed, which she did. I then examined her and there were no bruises". E12 stated that the staff, including herself, toileted the resident; made sure the wheel chair was locked; when the resident was in bed that the bed was in the lowest position; that the resident was dry, and that the call bell was at the bedside even if the resident could not always use it.

3/4/14 - At 3:40 PM, in an interview, E8 (Registered Nurse) stated that she got report on 2/1/14 from E7 who also worked a double 3 to 11 and 11 to 7 shifts. E8 stated that she had R2 as part of her assignment for the 2/1/14 to 2/2/14, 11 to 7 shift. E8 stated, "I go at the beginning of the shift, I think to give her medicine, there was no grimacing at that time. I did look at the area but did not measure it". E8 stated that on 2/2/14 about 4:57 AM that the CNA (Certified Nurse's Aide) told her that the resident had facial grimacing when she was turned and repositioned so, "I gave her Oxycodone (narcotic pain reliever) for pain. She had facial grimacing noted when her right arm was touched. Even though I did not document it, I saw that the right breast and under the right armpit had increased in size but I did not measure it. It was bruised, purple blue in color. At 6:48 AM, the size had increased more from earlier with bruising and I measured it. Then, I said we have to send her out, called the nurse supervisor and called the doctor".

3/4/14 - At 4:10 PM, in an interview, E4 (Registered Nurse, Director of Care Delivery) stated, "This was being monitored over the last 24 hours. I don't know if a two hour delay was significant. If she (referring to E8) saw it at 4:57 AM (on 2/2/14) and didn't feel she needed to call

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F 309	<p>Continued From page 22</p> <p>the doctor then, she did look at it at 6:48 AM and then did call the doctor and sent her out. We don't know how much difference there was in the 2 hours". E4 did acknowledge that R2 did require blood transfusions at the hospital.</p> <p>3/5/14 - At 7:40 AM, in an interview, E2 (Director of Nursing) stated that E8 was interviewed on 3/4/14, by herself and other facility staff, after the surveyor had interviewed E8 and had left for the day. E2 stated when asked the question as to what was increasing for R2 (referring to the swelling and the bruising of the right breast and under the armpit area on 2/2/14) that E8 stated that it was the size not the bruising that was increasing.</p> <p>The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being when it failed to:</p> <ul style="list-style-type: none"> - Assess/monitor and identify the significance of the increasing swelling and bruising at the right chest wall extending under the right armpit with progression to the left chest wall for R2, a Lovenox dependent resident with an abnormal Hgb; - Identify that R2 was on Lovenox, on 2/1/14 at 6:12 PM, when speaking with the doctor, despite the initial swelling at the right ribs area noted on 2/1/14 at 12:21 PM and initial bruising under the right breast first noted on 2/1/14 at 6:12 PM; - Obtain clarification from R2's doctor regarding whether to administer Lovenox on 2/1/14 at 8 PM and failed to provide the opportunity for the doctor to give further orders; - Do complete assessments and measurements of the swelling and bruising/bleeding of the right chest wall, armpit and left chest wall areas despite multiple opportunities and despite 	F 309		4/19/14

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developing symptoms from the onset on 2/1/14 at 12:21 PM to 2/2/14 at 6:48 AM. The time period was over eighteen (18) hours. The swelling and bruising/bleeding into the right chest wall/ breast area and under the armpit with progression to the left chest wall resulted in R2's hemoglobin dropping from 9.2 to 5.9. R2 was admitted to the hospital and required blood transfusions

1B. On 1/24/14, R2's doctor ordered Nystatin swish and swallow for three times a day for seven days as part of the plan of care when oral thrush (fungal infection where the mouth becomes sore and red, and white spots sometimes develop) was diagnosed.

A care plan entitled, "Infection of mouth - oral thrush" was initiated on 1/27/14 with the goal that the infection will be resolved without complications. Interventions included: "Administer medication per doctor's order..."

Review of the 1/2014 eMar (computerized Medication Administration Record) revealed that the order was incorrectly transcribed for six days and one dose rather than for seven days.

Additionally, since Nystatin was not dispensed promptly, R2 did not receive the first dose until 1/27/14 at 8 AM. The eMAR was not revised so R2 received only 11 out of 21 doses ordered.

The facility failed to follow the plan of care and failed to administer Nystatin as per R2's doctor's order. On 3/4/14 at 4:10 PM in an interview, E4 (Registered Nurse, Director of Care Delivery) confirmed the findings.

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2. Review of R5's care plan entitled, "ADL (activities of daily living) Self care deficit related to limited mobility (ability to move freely and easily), dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) and syncope (fainting)", initiated 4/2/13 and last revised on 8/7/13, had the goal of will receive assistance necessary to meet ADL needs with a target date of 5/21/14. Interventions included: "Restorative ambulation: Ambulate 300 feet with rolling walker and close supervision 2 x (times) day..."

R5 had two falls in early December 2013 and her doctor ordered Physical Therapy services. The Physical Therapy summary, with an initial date of 12/10/13, stated that R5 was evaluated on 12/10/13 due to, "s/p (status post/after) fall with gait dysfunction (abnormal style of walking), deconditioning/immobility (Deconditioning is a complex process of changes in the body following a period of inactivity or bedrest resulting in functional losses in such areas as mental status and ability to accomplish activities of daily living. /Immobility is the state of not being able to move around)"

On 1/14/14, upon completion of Physical Therapy services, R5's doctor ordered a Restorative Nursing Program [(RNP) restorative nursing interventions promote the resident's ability to adapt and adjust to living as independently and safely as possible] for R5 to ambulate with a single point cane, contact guard assistance (Have one or two hands on the person's body to help with balance.) for 200 feet 5 times per week.

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<p>F 309</p>	<p>Continued From page 25</p> <p>Review of the computerized CNA documentation from 1/15/14 through 2/24/14 revealed that R5 was incorrectly being ambulated with a roller walker and close supervision twice a day rather than a single point cane as per R5's doctor's order.</p> <p>On 2/24/14 at 1:10 PM, an observation was made of R5 walking in the hallway with a roller walker with E9 (Certified Nurse's Aide/CNA) holding a gait belt that was around the resident's waist for safety and E10 (CNA) pushing the wheelchair behind R5 in the event that she needed to sit down. The resident walked with the roller walker from her room to the elevator and back to her room.</p> <p>On 2/24/14 at 1:30 PM, in an interview, E9 stated that as part of the restorative nursing program that the resident was walked 300 feet with the rolling walker and close supervision twice a day unless she refused.</p> <p>On 2/24/14 at 2:10 PM, in an interview, E11 (Physical Therapist) stated that R5 had reached her maximum with physical therapy services and then was placed on a restorative nursing program on 1/14/14. E11 stated that it was his expectation that the facility would be following the program R5's doctor ordered for the resident on 1/14/14.</p> <p>The facility failed to follow R5's plan of care and implement the 1/14/14 doctor's orders for the restorative nursing program. On 2/24/14 at 2:27 PM in an interview, E4 (Registered Nurse, Director of Care Delivery) confirmed the findings.</p>	<p>F 309</p>	<p>F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>4/19/14</p> <p>It is the facility practice when a resident who is unable to carry out Activities of Daily Living receives the necessary services to maintain good nutrition, grooming, and personal and or oral hygiene.</p>
<p>F 312 SS=D</p>	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>	<p>F 312</p>	

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F 312	<p>Continued From page 26</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide, to a resident who was unable to carry out activities of daily living, the necessary services to maintain good grooming and personal hygiene for one (R1) out of six sampled residents. Findings include:</p> <p>R1 had diagnoses of dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) and delusions (a belief held with strong conviction despite evidence to the contrary).</p> <p>The care plan entitled, "ADL (activities of daily living) Self care deficit as evidenced by need for complete care related to disease process - dementia", was initiated on 3/28/07 with the goal that R1 will be clean, dressed, and well groomed daily to promote dignity and psychosocial well being with a target date of 4/16/14. Interventions included: Encourage resident to turn and reposition every 2 to 3 hours and as needed; Monitor for and report significant changes in ADL status to the doctor; Praise all efforts, not just successes; Provide assistance - complete care.</p> <p>The quarterly Minimum Data Set (MDS)</p>	F 312	<p>R1 was provided treatment and is receiving necessary services to maintain good grooming and personal hygiene.</p> <p>The Administrative Director of Nursing Services and or designee will audit all dependent residents' nails to monitor the residents are receiving necessary services to maintain good grooming and personal hygiene.</p> <p>The Staff Development Coordinator will in-service Certified Nursing Assistants on nail care. Demonstrate how to cut nails. Nurses are to check nail care during weekly body audits to evaluate residents nail care.</p> <p style="text-align: right;">4/19/14</p>

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assessment, dated 12/15/13, stated that R1 had short and long term memory problems and was severely cognitively impaired (mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently). R1's functional status on this MDS stated that the resident required extensive assistance of two persons for bed mobility, transfer and toileting and was totally dependent with assistance of one person for hygiene and bathing.

R1's Skin Alteration Record, dated 12/30/13, stated the following:
 -Other: Right thumb; Measurement: length 1.0 cm (centimeter, 1 centimeter = 0.39 inches), width 0.3 cm, depth 0.1 cm; Description of Alteration: Dark pink/red tissue; Drainage Serosanguinous - thin red (bloody); Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes;
 -Other: Left thumb; Measurement: length 1.0 cm, width 0.2 cm, depth 0.1 cm; Description of Alteration: Dark pink/red tissue; Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes;
 -Other: Left 2nd digit finger; Measurement: length 0.5cm, width 0.1 cm, depth 0.1 cm; Description of Alteration: Dark pink/red tissue; Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes;
 -Other: Left 3rd digit finger; Measurement: length 1.0 cm, width 0.2 cm, depth 0.1 cm; Description of Alteration: Dark pink/red tissue; Drainage Serosanguinous - thin red; Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes;
 -Other: Left 4th digit finger; Measurement: length 1.0 cm, width 0.2 cm, depth 0.1 cm; Description

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The Administrative Director of Nursing Services and or designee will monitor weekly when the weekly body audits are completed to evaluate the residents are receiving necessary nail care to maintain good grooming and personal hygiene. This will be done until 100% compliance is reached for 3 consecutive evaluations. Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

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of Alteration: Dark pink/red tissue; Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes;
-Other: Left 5th digit finger; Measurement: length 0.5cm, width 0.1 cm, depth 0.1 cm; Description of Alteration: Dark pink/red tissue; Amount: moderate; Skin Surrounding Alteration: normal appearance; Pain at site: yes."

Review of the 12/2013 electronic Medication Administration Record (eMAR) revealed that R1 was given Acetaminophen (Tylenol) two tablets routinely, twice a day at 8 AM and 4 PM for generalized pain. Additionally, R1 received Acetaminophen two tablets as needed for mild pain on 12/31/13 at 12:06 AM which was effective.

The facility's incident report for R1, dated 12/31/13 at 11:16 AM, stated, "Incident Date/Time 12/30/2013 at 9:30 PM; Incident Type: Injuries; ...Aide (E17, Certified Nurse's Aide/CNA) was asked by nurse to cut resident's finger nails. Aide cut resident's fingers nails then noticed one of her finger tips to be bleeding ... When aide and nurse went back to resident, 8 of 10 fingers then noted to be bleeding at finger tips ..."

The progress notes from 12/31/13 at 1:58 PM through 1/7/14 at 7:04 AM revealed that R1 had no further signs of discomfort or pain or infection.

The 1/2014 electronic Medication Administration Record (eMAR) was reviewed and R1 did not receive any additional prn (as needed) Acetaminophen for mild pain from 1/1/14 through 1/7/14.

Review of the 1/2014 electronic Treatment Record

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Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan. Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans

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(eTar) revealed that R1's second, third, fourth, fifth fingers and thumb on the left hand as well as the right thumb were treated with Bacitracin Zinc ointment (ointment that helps prevent infection in minor cuts) and dressings from 1/1/14 through 1/7/14.

The Skin Alteration Record for R1's second, third, fourth, fifth fingers and thumb on the left hand as well as the thumb on the right hand stated on 1/8/14 that all of the areas were resolved/healed.

On 2/21/14 at 11:30 AM an observation was made of the resident with E16 (CNA) and R1's finger nails were clean, trimmed and the skin surrounding the nails were intact.

The facility failed to ensure that R1, a resident who was dependent for ADLs, received the necessary services to ensure good grooming and hygiene on 12/30/13 when R1's nails were trimmed by facility staff resulting in 8 out of 10 fingers being cut and bleeding. On 2/21/14 at 11:40 AM, findings were confirmed by E5 (Licensed Practical Nurse, Unit Director) and E6 (Registered Nurse, Director of Care Delivery).

F 312
F329 DRUGS REGIMEN IS FREE FROM UNNECESSARY

It is the facility practice each residents' drug regimen 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 presences of adverse consequences which indicate the does should be reduced or discontinued; or any combinations of the reasons above

4/19/14

F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=E

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.

F 329
It is the practice of the facility to do comprehensive assessment of the resident the facility must ensure that residents' who have not used antipsychotic drugs are

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK		STREET ADDRESS CITY STATE ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 329 Continued From page 30

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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for one (R4) out of six sampled residents. The facility failed to ensure that there was an adequate monitoring for use of an increased dose of the antianxiety medication, Clonazepam and subsequent monitoring R4's response to the increase for multiple occasions between 2/1/14 and 2/27/14 Findings include:

R4 had diagnoses of dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning), depression (mental disorder with feelings of sadness) with psychotic (loss of contact/touch with reality) features and anxiety (general term for several disorders that cause nervousness, fear, apprehension, worrying, an unpleasant state of inner turmoil, often

F 329

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 received gradual dose reductions and behavioral interventions unless clinically contradicted in an effort to discontinue these drugs.

R4 drug regimen is being monitored for Clonazepam for behaviors that led to the increase and for response.

4/19/14

The Administrative Director of Nursing Services and or designee will audit:

- Residents that have new or increased behaviors to evaluate the behaviors are documented in the nurse's notes to ensure patients are being monitored for behaviors
- Attempt non-pharmacological interventions to include but not limited to psychology

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F 329	<p>Continued From page 31 accompanied by nervous behavior, such as pacing back and forth).</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 12/4/13, stated that R4 was severely cognitively impaired, had psychosis with delusions noted, had mood issues and active diagnoses that included an anxiety disorder.</p> <p>The care plan entitled, "At risk for adverse effects related to: use of antianxiety medication ..." was initiated on 7/21/10 and had the goal that R4 would show improvement in mood/behavior with a target date of 4/16/14. Interventions included: Attempt dose reduction as ordered. Monitor for effect of change and notify physician in any decline ADL (activities of daily living) ability or mood/behavior; Give opportunity to perform portions or as much of the ADLs on her own as tolerated; Monitor mood state/behavior; Notify family/significant others of changes.</p> <p>The care plan entitled, "At risk for adverse effects related to: use of antianxiety ... medication" initiated on 12/22/11 had the goals that R4 would show minimal/no side effects of medications taken, perform to the highest level of ADL independence and show improvement in mood/behavior with a target date of 4/16/14. The intervention was to notify the doctor and family/significant other of changes in behaviors.</p> <p>According to psychiatric progress notes, R4 was last seen on 1/28/14. The note, dated 1/28/14, stated that R4 had a major depression with psychotic features that included religious delusions, that the resident was on Klonopin (Clonazepam) 0.25 mg (milligrams) at bedtime and the psychiatric revisit would be as needed.</p>	F 329	<ul style="list-style-type: none"> • If non-pharmacological interventions are not effective then the primary physician is notified for further interventions to include but not limited to consulting facility psychiatrist/psychiatric nurse practitioner • If the psychiatrist/psychiatric nurse practitioner or primary care physician starts and/or increases a psychoactive medication the facility will monitor for its effectiveness in nursing documentation which will be reviewed in morning and afternoon meeting • The family is notified of new or increase in behaviors and of new orders. • The pharmacy consultant does monthly medication review of all residents and makes recommendations to the physicians. 	ee 1e 4/19/14

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F 329

Continued From page 32

R4's progress notes were reviewed and revealed the following notes: "2/1/14, 03:32 AM Received pt (patient) resting in bed. No s/s (signs/symptoms) distress noted. Easily aroused. Staff assists pt with toileting needs. Fluids provided as needed. No adverse rxn (reaction) noted at this time with medications. Will continue to monitor; 2/1/14, 09:52 AM SS (social services) reviewal of notes: 2/4/14, 06:57 AM Milk of Magnesia ... for constipation; 2/4/14, 11:35 AM PRN (as needed) Administration was: Effective (Referring to the Milk of Magnesia given for constipation, R4 had a bowel movement.); 2/8/14, 02:58 AM Patient A&Ox1 (alert and oriented to person only) Incontinent (loss of control) of B&B (bowel and bladder)...Tolerated all care and medications well. No s/s of any acute distress ... Denies c/o (complaint of) pain or discomforts. Call bell within reach." Despite this documentation there was a lack of evidence of behavioral issues recorded and monitoring for R4 in these progress notes.

On 2/18/14 a verbal order was obtained from R4's doctor by E18 (Licensed Practical Nurse) for the antianxiety medication, Clonazepam that stated, "Discontinue Clonazepam 0.25 mg (milligrams) by mouth at bedtime for anxiety and HOLD FOR SEDATION" and the doctor then verbally ordered, "Clonazepam 0.25 mg by mouth two times a day for anxiety HOLD FOR SEDATION".

There was no progress note written for 2/18/14 that described R4's behavior and the reason for the increase in Clonazepam to twice a day.

Observations of the resident were as follows: On

F 329

The Staff Development Coordinator and or designee will in-service the nursing staff on:

- Residents that have new or increased behaviors are documented in the nurse's notes
- Attempt non-pharmacological interventions to include but not limited to psychology
- If non-pharmacological interventions are not effective then the primary physician is notified for further interventions to include but not limited to consulting facility psychiatrist/psychiatric nurse practitioner
- If the psychiatrist/psychiatric nurse practitioner or primary care physician starts and/or increases a psychoactive medication the facility will monitor for its effectiveness and document in nursing notes
- The family is notified of new or increase in behaviors and of new orders.

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F 329

Continued From page 33
2/20/14 at 12:25 PM, R4 was observed in her room, dressed, wearing shoes and was asleep, lying on top of the bed; On 2/21/14 at approximately 9:15 AM, R4 was observed dressed, wearing shoes, walking in the hallway just outside of the dining room. R4 was holding onto the handrail as she walked. Then, resident walked down to her room and was observed lying on top of the bed with a cover over her; On 2/24/14 at 11:35 AM, R4 was observed walking in the hallway holding the handrail and began to wander into another resident's room. R4 was observed being redirected by E16 (Certified Nurse's Aide). On 2/26/14 at 8:55 AM, R4 was observed with E16 who encouraged the resident to go to the dining room for breakfast. On 2/26/14 at approximately 9 AM, in an interview, E16 stated that she had been to the resident's room a couple of times before but that the resident was sleeping. The resident was observed walking down the hallway being assisted by E16. On 2/26/14 at approximately 9:10 AM, E16 was observed reporting to E19 (Licensed Practical Nurse) that R4 was not walking as well as usual and they both went to R4 and asked if her legs were hurting and R4 replied, "Yes".

The next progress notes for R4 were as follows "2/26/14, 09:23 AM, c/o (complaining of) bil. (bilateral/both) legs aching; 2/26/14, 11:48 AM PRN (as needed) administration (of Acetaminophen/Tylenol) was effective". Again, these progress notes failed to address R4's behavior and response if any noted to the increased Clonazepam.

On 2/26/14 at 1 PM, in an interview, E6 (Registered Nurse, Director of Care Delivery) stated that residents' behaviors were monitored in

F 329

The Administrative Director of Nursing Services and or designee will do weekly audits on:

(Facility sample includes residents with new or increased behaviors or new or increased psychoactive medications)

- Residents that have new or increased behaviors to evaluate the behaviors are documented in the nurse's notes to ensure patients are being monitored for behaviors
- Attempt non-pharmacological interventions to include but not limited to psychology
- If non-pharmacological interventions are not effective then the primary physician is notified for further interventions to include but not limited to consulting facility psychiatrist/psychiatric nurse practitioner

4119

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F 329 Continued From page 34
the nurses'/progress notes.

On 2/27/14 at 10:10 AM, in an interview, E18 reviewed R4's doctor's orders and progress notes and stated that she failed to write a progress note on 2/18/14 when she got the verbal order from the doctor. When the surveyor asked E18 why the Clonazepam order was obtained to increase it to twice a day, E18 stated it was due to R4's increased pacing, being more anxious. However, after review of the progress notes, E18 stated that there were no notes regarding R4's behavior and monitoring of the behavior. E18 stated that she really has not seen much change yet with the increase of Clonazepam to twice a day. E18 further agreed that without monitoring of R4's behavior and response to the increased medication, it would be difficult to determine if the approach was appropriate or effective or if another approach was indicated. E18 then stated, "There should be notes written (referring to behavioral monitoring and medication changes in the progress notes)".

On 2/27/14 at 11:40 AM, in an interview, E1 (Administrator) was asked for a policy and procedure for behavior monitoring and medication use. E1 stated that she checked on the computer and the facility did not have a policy.

The facility failed to ensure that R4's drug regimen was free from unnecessary medication when there was a lack of monitoring for R4's behavior that led to an increase in Clonazepam, an anti anxiety medication and a lack of monitoring of the resident's response. On 2/27/14 at 10:10 AM, E18 confirmed the findings.

- F 329
- If the psychiatrist/psychiatric nurse practitioner or primary care physician starts and/or increases a psychoactive medication the facility will monitor for its effectiveness in nursing notes ed a lan.
 - The family is notified of new or increase in behaviors and of new orders. /iew he ter
 - The above will be monitored through Eagle Room morning and afternoon meeting.
 - The pharmacy consultant does monthly medication review of all residents and makes recommendations to the physicians.
 - The facility has a monthly psychoactive review committee meeting.

4119114

This will be done until 100% compliance is reached for 3 consecutive evaluations.

Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

Attachment

Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan.

Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans

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F 425 Continued From page 35
F 425 483.60(a),(b) PHARMACEUTICAL SVC -
SS=D ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined that the facility failed to provide pharmaceutical services including the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (R2) out of six sampled residents. Findings include:

On 1/24/14, R2's doctor ordered Nystatin [medication for an infection] swish and swallow for three times a day for seven days when oral thrush (fungal infection where the mouth

F 425
F 425

F425 PHARMACEUTICAL
SVC-ACCURATE
PROCEDURES. RHP

The facility practice to provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in 483.75(h) of this part period. Facility may permit unlicensed personnel to administer drugs if the state law permits, but only under the general supervision of a licensed nurse.

It is the facility practice to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispense, and administering of all drugs and biological) to meet the need of each resident.

It is the facility practice to employ or obtain the services of a licensed pharmacist who provided consultation on all aspects of the provision of pharmacy services in the facility.

R2 no longer resides in the facility

4/1/14

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F 425 Continued From page 36
becomes sore and red, and white spots sometimes develop) was diagnosed.

R2's Nystatin was not dispensed promptly from the facility's pharmacy. R2 did not receive the first dose until 1/27/14 at 8 AM, three days after it was ordered.

Review of the 1/2014 facility's eMAR (electronic Medication Administration Record) revealed that the dates of administration were not revised or recalculated after the late arrival of the medication. R2 received only 11 out of 21 doses ordered.

The facility's pharmaceutical services failed to promptly dispense the medication, Nystatin, to R2 as ordered. On 3/4/14 at 4:10 PM, in an interview E4 (Registered Nurse, Director of Care Delivery) confirmed the findings.

F 514 SS=D 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

F 425

- The Administrative Director of Nursing Services and or designee will audit residents on Nystatin and other medications to evaluate that pharmacy services dispensed Nystatin and other medications promptly as ordered; and the MAR was revised to reflect that all doses ordered are administered.

The Staff Development Coordinator will in-service the nursing staff:

4/12/14

F 514

- If resident is on Nystatin (and other medications) and it is not available per physician's order to notify physician
- If the physician still wants medication order: call the pharmacy and request back up Pharmacy to deliver the medication.
- Revise the MAR to reflect that all doses ordered are administered

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F 514

Continued From page 37

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete for two (R2 and R4) out of six sampled residents. Findings include:

1. On 2/1/14 at 12:21 PM, R2's progress note stated, "... Noted with a 9 cm (centimeter) x (by) 11 cm semi hard swelling to her upper right chest wall extending under her right armpit. Resident c/o (complained of) pain when area is touched. No redness, warmth, or bruising noted. Call put out to MD (doctor)".

Review of R2's progress note, dated 2/2/14 at 3:16 AM, revealed a late entry for 2/1/14 that stated, "Resident noted with bruising under right breast of about 10 cm (centimeter, 1 centimeter = 0.39 inches) by 5 cm. No warmth, but tender when touched. MD (doctor) made aware. new order to make a note for patient to be seen on Monday (2/3/14)".

On 2/2/14 at 4:57 AM, R2's progress note only stated, "C/o (complaining of) pain, facial grimace noted when rt (right) arm is touched"

On 3/4/14 at 3:40 PM, in an interview, E8 (Registered Nurse) stated, "I go at the beginning of the shift. I think to give her medicine, there was no grimacing at that time. I did look at the area but did not measure it". E8 stated that on 2/2/14 about 4:57 AM that the Certified Nurse's Aide told her that the resident had facial grimacing when she was turned and repositioned so, "I gave her Oxycodone (narcotic pain reliever) for pain. She

F 514

The Administrative Director of Nursing Services and or designee will monitor weekly residents on Nystatin and other medications to evaluate the residents plan of care is followed and administered per doctor's order.

This will be done until 100% compliance is reached for 3 consecutive evaluations.

Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan.

Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.

4/19/14

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F 514

Continued From page 38
had facial grimacing noted when her right arm was touched. Even though I did not document it, I saw that the right breast and under the right armpit had increased in size but I did not measure it. It was bruised, purple blue in color

The facility failed to have complete documentation of the progress notes in the clinical record for R2's record on 11 to 7 shift (night shift), 2/1/14 into 2/2/14. On 3/4/14 at 3:40 PM, E8 confirmed the findings.

2. Review of R4's clinical record revealed that it was not complete as follows:
- A. The verbal order was not printed off for R4's doctor to sign that included to discontinue Clonazepam (an antianxiety medication) 0.25 mg (milligram) by mouth at bedtime for anxiety and then the order to increase Clonazepam 0.25 mg by mouth to twice a day for anxiety. This was not printed off until 2/26/14 when brought to the facility's attention by the surveyor.
 - B. On 2/18/14, there was no nurses's note/progress note for R4 written to document the medication changes nor the resident's behavior that initiated the verbal order for the increase in Clonazepam.
 - C. There was no nurses' note/progress note written that documented that R4's representative was notified of the behavioral and medication changes on 2/18/14. On 2/27/14 at 8:45 AM, the surveyor was able to speak with the representative and she confirmed that she was notified.

The facility failed to have a complete record and documentation for 2/18/14 as noted above. On 2/27/14 at 10:10 AM, E18 (Licensed Practical

F 514

F514 RECORDS-
COMPLETE/ACCURATE/ACC
ESSIBLE

It is the facility practice to maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

It is the facility practice the clinical record must contain sufficient information to identify the resident: a record of residents' assessment; the plan of care and services provided; the results of any pre-admission screening conducted by the state; and progress notes.

1. R2 no longer resides in the facility.

The Administrative Director of Nursing Services and or designee will do a random audit of residents identified with bruising and or swelling

4/19/14

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STATEMENT OF DEFICIENCIES (1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 085033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
		(X5) COMPLETION DATE	

F 514 Continued From page 39
Nurse) confirmed the findings.

F 514 to evaluate the progress note
has complete documentation
in the clinical record.

The Staff Development
Coordinator and or designee will
in-service nursing staff on
completing documentation of
progress notes in the clinical
record.

The Administrative Director of
Nursing Services and or designee
will do a weekly random audit of
patients identified with bruising
and or swelling to evaluate the
progress note has complete
documentation in the clinical
record.

4/19/14

This will be done until
100% compliance is
reached for 3 consecutive
evaluations.

Then monitor weekly
until we reach 100%
success over 3
consecutive evaluations.



**DELAWARE HEALTH
AND SOCIAL SERVICES
(DHSS)**

Division of Long Term Care
Residents Protection (DLTCRP)

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

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Pike Creek

DATE SURVEY COMPLETED: March 5, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>Revised report following IDR. Text changes made to F309 on the federal report.</p> <p>An unannounced complaint survey was conducted at this facility from February 20 through March 5, 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 156. The survey sample was six which included (5) five active residents and (1) one closed record.</p> <p>Skilled and Intermediate Care Nursing 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:</p>	<p>Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.</p> <p>Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan.</p> <p>Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans</p> <p>2. R4 clinical record and documentation have been completed. There is written documentation of the medication changes and the residents behavior related to Clonazepam. The documentation of representative notified is in the clinical record and verbal order was printed and signed by physician.</p> <p style="text-align: right;">4/19/14</p>

Provider's Signature

Mary Callahan

Title

NHA

Date

5/6/14



NAME OF FACILITY: Manor Care Pike Creek

DATE SURVEY COMPLETED: March 5, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Cross refer to the CMS 2567-L survey completed 3/5/14, F157, F225, F280, F309, F312, F329, F425 and F514.</p>	<p>The Administrative Director of Nursing Services and or designee will do weekly random audits of the clinical record of patient on Clonazepam to evaluate the clinical record has complete documentation why medication changes and the residents behavior that initiated the increase.</p> <p>Physician verbal order is signed. Representative notification documented in the clinical record.</p> <p>The Staff Development Coordinator or designee will in-service the nursing staff on:</p> <ul style="list-style-type: none"> • Verbal order needs to be signed by the physician when Clonazepam is discontinued • Documenting in the nurses progress notes when changes in resident Clonazepam and document the behaviors that initiated the changes in the Clonazepam. <p style="text-align: right;">4/19/14</p>

- Documenting notified residents representative of behavior and Clonazepam changes.

The Administrative Director of Nursing Services and or designee will do weekly audits on the clinical record of patient on Clonazepam to evaluate the clinical record has complete documentation why medication changes and the residents behavior that initiated Verbal order is signed by doctor when Clonazepam is d/c. Documented notified the representative of Clonazepam change

This will be done until 100% compliance is reached for 3 consecutive evaluations.

Then monitor weekly until we reach 100% success over 3 consecutive evaluations.

4/1/19

Finally the facility will monitor one more time a month later if 100% compliant then will no longer monitor.

Quality Assessment and Assurance Committee initiated a Quality Milestones Action Plan.

Results of the audits will be submitted to the Quality Assurance committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans

Cross Refer to the CMS 2567-L survey

Completed 3/5/14 F157, F225, F280, F30

F312, F329, F425 and F514

L

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