

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

PRINTED: 04/24/2015
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 04/15/2015
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 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility from March 24, 2015 and ended on April 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as well as hospital documents as indicated. The facility census the first day of the survey was 167. The survey sample included (8) eight sampled residents and (6) sub sampled residents.</p> <p>Abbreviations used in this 2567 are as follows: DON - Director of Nursing; DCD - Director of Care Delivery; RN - Registered Nurse; LPN - Licensed Practical Nurse; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; NHA- Nursing Home Administrator; MAR - Medication Administration Record; TAR-Treatment Administration Record; eMAR - electronic Medication Administration Record; ADL-activities of daily living, i.e., bathing, dressing, personal hygiene, toilet use; Hyponatremia - water intake being less than water loss; mg - milligram (unit of mass); ml - milliliter (unit of volume); L-liter - volume of a liquid; cc - cubic centimeter (unit of volume); cm - centimeter (unit of length); hr-hour; IV-Intravenous infusion-into the vein; D5W-Dextrose [sugar]5%Water;</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>		

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

TITLE

(X6) DATE

May Colleen Raf

LNHA

5/5/15

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

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F 000	Continued From page 1 D5NS-Dextrose 5% in Normal Saline [salt water]; D5%NSS-Dextrose 5% in Normal Saline Solution; MDS - Minimum Data Set (standardized assessment form used in nursing homes).	F 000	F157 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 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).		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	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).		

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F 157	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview, and review of other facility documentation as indicated, it was determined that for two (R5 and R6) out of 8 sampled residents, the facility failed to ensure that these residents' known interested family members were immediately notified when there was a significant change in the resident's physical status, a need to alter or commence a new form of treatment and an incident involving a nursing error in implementing the physician's order. The facility failed to notify R5's interested family member of a change in her physical status on 1/27/15 and of a new order for an x-ray on 1/28/15. R5's family was notified approximately 34 hours after an x-ray result revealed that R5 had an acute fracture of the 5th toe on her left foot. The facility failed to insure that R5's interested family member, was notified when there was a need to commence a new form of treatment due to poor oral intake and hypernatremia and after an error was discovered in the administering of the new treatment that required physician intervention. Findings include: Cross-refer to F309 example 1 1. R5 was admitted to the facility on 12/1/14. Review of R5's clinical record revealed a nurse's note, dated 1/27/15 at 11:28 AM, which stated, "late entry: noted resident's left foot to be swollen to approx. (approximate) mid shin. No c/o (complaint of) of pain when foot was touched, no bruising to foot, slightly red, skin cool. All of the above info (information) faxed to md (medical doctor). Attempted to elevate foot but resident refused". The clinical record lacked evidence that R5's family was notified of the change in physical	F 157	Resident R 6 no longer resides in the facility. Resident R5's family was notified of her change in physical status on January 28, 2015. The Administrative Director of Nursing Services and or Designee will audit resident's charts when it has been identified of change physical status, change in condition, adverse consequences to evaluate the family and physician were notified timely of the change. <i>Attachment</i> The Staff Development Coordinator and or Designee will in-service staff that when a resident has a change in physical status, change in condition, adverse consequence's the family and physician must be notified timely. For example: x-ray results medication error bruises fracture toe room change	6/6/15 6/6/15	

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F 157	<p>Continued From page 3 status.</p> <p>A nurse's note, dated 1/28/15 at 10:37 AM, stated, "pt (patient) with pain and swelling to left (sic/left) foot, ... PA (physician assistant) in ordered x-ray ... x-ray to be done today". The clinical record again lacked evidence that R5's family was notified of the new order for an x-ray.</p> <p>A nurse's note dated 1/28/15 at 9:19 PM, stated, "X-ray results (sic) shows acute fracture (break) involving 5th (toe)...Family notified".</p> <p>Review of R5's clinical record revealed that the family was notified approximately 34 hours after there was a change in physical status for R5.</p> <p>In an interview on 3/26/15 at 2:50 PM, E4 (LPN) stated that she did not notify R5's family on 1/27/15. The facility failed to notify R5's family of a change in a physical status on 1/27/15 and of a new order for an x-ray on 1/28/15.</p> <p>2. On 10/1/14, a new form of treatment was ordered by E17 (NP/Nurse Practitioner) for R6 due to a decline in poor oral intake and symptoms of hypernatremia. The new treatment was ordered on 10/1/14 as I.V. D5W at 50 ml/ (per)hour x (times) 2 liters.</p> <p>E7 (LPN) stated in her nurse's note dated 10/1/2014 at 14:45 (2:45 PM), "Pt. (patient) seen by (E17) this shift with new orders for I.V. D5NS at 50cc/hr x 2 L..."</p> <p>A nurse's note dated 10/2/14 stated, "On 10/2/14 at approx. (approximately) 7:30 am the patient and nurse practitioner were notified that D5NS</p>	F 157	<p>The Administrative Director of Nursing Services and or Designee will perform daily audits of resident's charts to evaluate that when</p> <p>Resident has a change in physical status, change in condition, adverse consequence's the family and physician must be notified timely.</p> <p>This will be done until 100 % compliance of three consecutive evaluations.</p> <p>Then, will monitor weekly until 100% compliance over three consecutive evaluations</p> <p>Finally will monitor one more time a month later. If 100% compliance then will no longer monitor.</p> <p><i>attachment</i></p>	6/16/15	

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F 157	Continued From page 4 was infusing instead of D5W. Patient alert and oriented x3 (place, time and person) ..., patient said "okay" when he was informed..." A nursing error occurred in implementing the physician's order and administering this treatment. The facility initiated an incident report, dated 10/2/14 and indicated that the resident was notified, however, there was no documented evidence that the known interested family member was also notified, in case, the resident may not be able to notify them personally. There was no documentation to support that R6 was given instruction for him to notify the interested family member himself. On 10/14/14 at approximately 12:42 PM, during an interview by the State Agency's Investigator with E19 (LPN), she failed to confirm that the interested family member was notified and or knew about the incident. The facility failed to ensure that the interested family member was also immediately notified of R6's new form of IV treatment and the incident of an error in administering the treatment. In a telephone interview with E11 (RN, DCD) on 4/15/15 at approximately 1:15 PM, he acknowledged this finding.	F 157	Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans. F246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES It is the practice of the facility to provide reasonable accommodations of needs/preferences. A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Resident SS5 call bell was placed within reach.	6/6/15 6/6/15	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of	F 246			

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F 246	Continued From page 5 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to accommodate one (SS5) out of 6 sub sampled residents with regard to the call bell being within reach. Findings include: On 3/31/15 at 9:12 AM, SS5 was observed out of bed, sitting in her wheelchair next to the right side and near the foot of her bed. As the nurse was attending to her roommate, SS5 asked to have someone get her up and dressed. SS5 looked at the surveyor and asked, "Do you see a call bell?" The surveyor observed the call bell clipped to the privacy curtain on the other side of the bed, out of the resident's reach. During an interview on 3/31/15 at approximately 9:15 AM, E15 (CNA) confirmed the findings and stated that she had clipped the call bell to the curtain while making up the resident's bed and forgot to replace it. She confirmed that SS5 was capable of using the call bell but that it was not within her reach. Findings were reviewed during the exit meeting with E1 (NHA) and E2 (DON) on 3/31/15 at approximately 4:35 PM.	F 246	The Administrative Director of Nursing Services and or Designee will audit the resident's rooms to evaluate the call bells are within reach. <i>@ Attachment</i> The Staff Development Coordinator and or Designee will in-service staff that the resident's call bell should always be within reach. The Administrative Director of Nursing Services and or Designee will perform daily audits of residents' rooms to evaluate that residents' call bell is within reach, until 100% compliance of three consecutive evaluations. Then, will monitor weekly until 100% compliance over three consecutive evaluations Finally the facility will monitor one more time a month later. If 100% compliance will no longer monitor. <i>attachment</i>	6/16/15 6/16/15	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278			

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F 278	<p>Continued From page 6 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that for one (R8) out of eight sampled resident's MDS assessment, accurately reflected the resident's status as related to Section I Active Diagnosis. Findings include:</p> <p>According to R8's Significant Change in Condition MDS assessment, dated 01/24/15, this resident's BIMS (Brief interview for Mental Status) score for</p>	F 278	<p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans</p> <p>F278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>It is the practice of the facility that the assessment must accurately reflect resident's status. Registered Nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A Registered Nurse must sign and certify the assessment is completed, each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>R8, no longer resides in the facility. R8's MDS assessment has been coded accurately to reflect the resident's status.</p>	6/6/15 6/6/15
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F 278	Continued From page 7 thinking and memory was "00" out of "15" indicating severe impairment. F8 was totally dependent on staff for ADLs. A nurse's note, dated 12/17/14 stated, "Resident was having difficulty bearing weight on his left leg this morning ... Received order to X-ray left hip, knee and ankle ... X-ray called into (name of X-ray provider) ... Received results from all X-rays which showed Osteoarthritis (a progressive disorder of the joints). No fracture (broken bones) ... Received new order for Naproxen (anti-inflammatory drug) 250 mg PO (per mouth) BID (twice a day) x (times) 3 days and PT (Physical Therapy) evaluation for gait dysfunction...". The facility developed a care plan, dated 2/18/14 and entitled, "Pain-left hip and knee, right ankle (hx (history) of fracture) evidenced by non-verbal expression of pain related to osteoarthritis". The Significant Change in Condition (MDS assessment, dated 01/24/15, failed to identify the diagnosis of Osteoarthritis under the section of "Musculoskeletal". Findings were reviewed during the exit meeting with E1 (NHA) and E2 (DON) on 3/31/15 at approximately 4:35 PM.	F 278	The Regional MDS Coordinator and or Designee will complete audits of MDS coding to evaluate that the MDS accurately reflects the resident's status. <i>attachment</i> The Regional MDS Coordinator will in-service MDS Staff on coding MDS accurately to reflect the resident's status include any significant changes. The MDS Coordinator and or Designee will do weekly audits of the MDSs to monitor the MDS accurately reflects the residents status until 100% compliance is reached over three consecutive evaluations. Then the MDS Coordinator and or Designee will monitor Bi-weekly until 100% compliance is reached over three consecutive evaluations. Finally the MDS Coordinator will monitor one more time a month later. If 100% compliance then will no longer monitor.	6/6/15 6/6/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans	<i>attachment</i>	

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F 281	<p>Continued From page 8</p> <p>by: Based on record review, interview and observation, it was determined that the facility failed to ensure that services provided or arranged by the facility met professional standards of quality for one (1) (R6) out of eight sampled residents and for one (1) (SS1) out of 6 sub sampled residents. The facility failed to ensure that the IV fluid that was hung for one (R6) resident was the same as the written physician order. For SS1, who was observed during the medication observation pass, the facility failed to ensure that all of her medication was administered by a licensed nurse. Findings include:</p> <p>Cross-refer to F309 example 2. The 8 rights of medication administration according to Lippincott Nursing Center.com dated 5/27/2011 included: "... Right medication, ... Right documentation ... 2. Right medication included: Check the medication label; Check the order ... 6. Right documentation included: Document administration after giving the ordered medication; Chart the time, route, and any other specific information as necessary as for example the site, vital signs ...".</p> <p>On 10/1/2014 at 12:55 PM E17 (NP) wrote in R6's progress note "...Diagnosis: Hyponatremia, poor PO (by mouth) intake, Plan: Will give D5W at 50 ml/hr (milliliters per hour),..."</p> <p>Review of R6's record revealed a physician's order dated 10/1/14 that was written as, "D5W at 50 ml/hr x (times) 2 L. E7 (LPN) received the order as indicated by her signature on the Physician's Order Form. E17 (NP) signed the order.</p>	F 281	<p>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>It is the practice of the facility that services provided meet professional standards of quality.</p> <p>R6 and SS1 no longer resides in the facility</p> <p>The Administrative Director of Nursing and or Designee will do daily observation audits:</p> <ul style="list-style-type: none"> of all resident's with IV fluids/medications to confirm that the physician's written order matches the IV fluid/medication that is hanging <i>at Hackman</i> Medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to licensed nursing staff and maintained under a locked system when not actively utilized and no medications are left at bedside unless the resident has physician's order to self-administer. Medication pass observation to audit the 6 Rights of Medication administration are being followed 	<p><i>4/6/15</i></p>

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F 281	<p>Continued From page 9</p> <p>The order was transcribed onto R6's (October 2014 MAR as "I.V. D5W at 50cc/hr ...started 10/1/14 at 1400 (2:00 PM) every shift for poor intake and hyponatremia (sic) ..."</p> <p>Review of R6's clinical record revealed the following sequence of events: A nurse's note dated 10/2/2014, E11 (RN/DCD) wrote "On 10/2/14 at approx. (approximately) 7:30 am the patient and nurse practitioner (E17) were notified that D5NS was infusing instead of D5W"...The nurse practitioner (E17) ordered blood work and also "to continue with D5W at 50cc/hr."</p> <p>An incident report dated 10/2/14 at 7 AM, stated, "D5W ordered. D5NSS running at the time. Two hundred fifty (250) cc remaining from the 1000 cc bag."</p> <p>The facility's Investigation Report dated 10/10/14 stated, "Patient was ordered D5W and D5NSS was running. On 10/2/14 during wound rounds, DCD (E11) noted that IV fluids infusing was D5NSS. IV fluids stopped as DCD recalled seeing an order that read D5W...nurse was educated on different IV fluids available".</p> <p>On 3/26/15 at approximately 1:30 PM, E11 (RN/DCD) confirmed to the surveyor that the bag of D5NSS solution was the IV bag found running instead of the 5% DW as ordered. R6 was infused 750 cc of the D5NSS before this error was discovered.</p> <p>Review of R6's record and the facility's investigation report also revealed the following:</p>	F 281	<p>The Staff Coordinator and or Designee will in-service on:</p> <ul style="list-style-type: none"> The 6 rights of medication administration including IV fluids/medications The medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to licensed nursing staff and maintained under a locked system when not actively utilized and that medications will not be left at bedside unless the resident has a physician's order to self-administer <p>The Administrative Director of Nursing Services and or Designee will monitor weekly x 3 the following until we consistently reach 100% compliance over three consecutive evaluations:</p> <ul style="list-style-type: none"> of all resident's with IV fluids/medications to confirm that the physician's written order matches the IV fluid/medication that is hanging 	6/16/15 6/16/15
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 04/15/2015
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 281	<p>Continued From page 10</p> <p>During the approximate 17 hour (2:00 PM-7:30 AM) period that the bag of D5NS was infusing, according to the 10/14 MAR flow sheet, on 10/1/2014 at 2:45 PM, E8 (LPN) signed off with a check mark that R6 was receiving IV fluids. She stated on her investigation statement dated 10/15/14 that the first IV bag was hanging, however, she "could not remember" if she verified that the IV fluid hanging was the same as the written physician order on the MAR.</p> <p>According to the 10/14 MAR flow sheet, on 10/1/14 at 10:45 PM, E9 (RN) signed off with a checked mark that R6 was receiving IV fluids. E9 stated on her investigation statement dated 10/16/14 that she looked at it (IV) and she "thought it was the right one". E9 failed to verify that the IV fluid hanging was the same as the written physician's order on the MAR and therefore, failed to identify that the infusing solution was incorrect.</p> <p>According to the same 10/14 MAR flow sheet, on 10/2/14 at 6:45 AM, E10 (RN) signed off with a check mark that R6 was receiving IV fluids. E10 failed to identify that the IV solution was incorrect.</p> <p>The facility failed to ensure that services provided met R6's needs in accordance with the physician's order. E7 failed to check the IV bag label with the written physician's order before hanging the IV bag. E8, E9, and E10 failed to verify the hanging IV solution with the written physician's order and/or the MAR during their nursing monitoring rounds to check the status of this infusing IV and therefore, failed to identify that the IV solution was incorrect.</p> <p>Findings were reviewed during the exit meeting</p>	F 281	<ul style="list-style-type: none"> • Medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to licensed nursing staff and maintained under a locked system when not actively utilized and no medications are left at bedside unless the resident has physician's order to self-administer. • Medication pass observation to audit the 6 Rights of Medication administration are being followed <p>Then will monitor monthly x2 until we consistently reach 100% compliance over 3 consecutive evaluations</p> <p>Finally will monitor one more time a month later. If 100% compliance then will no longer monitor.</p> <p><i>attachant</i></p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans</p>	6/6/15 6/6/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 036033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5881 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 281	<p>Continued From page 11 with E1 (NHA) and E2 (DON) on 3/31/15 at approximately 4:35 PM.</p> <p>2. Review of the facility's policy, dated 12/2014 and entitled, "Medication and Treatment Administration Guidelines" stated, "... Medication Storage and Security: Medications ... are securely stored in a locked cabinet, cart or medication room, accessible only to licensed nursing staff and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration...".</p> <p>Review of the facility's policy, dated 1/1/8 and entitled, "Self Administering Medications" stated, "... Nursing Center should ensure that orders for self-administration list the specific medication(s) the resident may self-administer...".</p> <p>During a medication pass observation on 3/30/15 at 3:50 PM, E12 (RN) was unable to find SS1's nasal spray in the medication cart. SS1 was ordered, "Deep Sea (normal saline/salt water solution) Nasal spray - administer 1 spray each nostril every 2 hours while awake". Upon going to SS1's room, the nasal spray was observed on the bedside table. E12 offered to administer the nasal spray, but SS1 refused, stating that she had already administered it to herself. E12 confirmed that SS1 did not have an order to self-administer medications and should not have any of her medications stored at the bedside.</p> <p>During an interview on 3/31/15 at 10:55 AM, E13 (RN/DCD) confirmed the findings, stating that she was investigating the matter. E13 confirmed that SS1 did not have a doctor's order to self-administer any medications.</p>	F 281		

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5661 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 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews and review of other documentation including photographs, it was determined that for three (R5, R6 and R7) out of 8 sampled and for one (SS2) out of 6 sub sampled residents, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being in accordance with the plan of care. The facility failed to identify bruises on R5's bilateral upper arms during multiple opportunities prior to R5's transfer to the ER (emergency room) and upon her return to the facility approximately 5 hours later. An incorrect IV bag of D5NSS was infused into R6 for 17 hours (2:00 PM-7:30 AM) instead of the physician's ordered D5N. While it was infusing, the error was not identified on multiple occasions on three different shifts during which required individual monitoring rounds of R6's infusing I.V. bag solution occurred. R6 was infused a total of 750 cc of the wrong solution before it was finally discovered by E11 (7-3 PM RN/DCD) the following morning. For SS2, who was observed during the medication observation pass, the facility failed to ensure the correct dose of Vitamin D3 was prepared for administration as per the doctor's orders. Additionally, the facility</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>It is the practice of the facility that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.</p> <p>1. R5's family was notified of change in her physical status March 27, 2015.</p> <p>The Administrative Director of Nursing Services and or Designee performed an initial building wide skin sweep of all residents to identify bruising or other alterations in skin integrity (this was completed on March 28, 2015), if any new alterations were identified, an incident report was completed and the physician and family were notified.</p> <p>The Administrative Director of Nursing Services and or Designee will perform building wide skin sweeps of all residents to identify bruising or other alterations in skin integrity, if any new alterations are identified, an incident report will be completed and the physician and family will be notified. These sweeps will</p>	6/16/15	

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

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5561 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 309	<p>Continued From page 13</p> <p>also failed to follow the plan of care and to review all drug allergies listed for one resident (R7) prior to the administration of a medication documented as an allergen. Findings include:</p> <p>1. The facility's "Skin Practice Guide", dated 1/2013, stated, "... Skin Observations: Nursing assistants perform daily skin observations with routine care ... Patients at risk for skin breakdown have a head-to-toe skin evaluation weekly by a licensed nurse ... Documentation of the evaluation is located in the Treatment Administration Record or progress note..."</p> <p>R5 was admitted to the facility on 12/1/14 for rehabilitation after a left hip fracture (broken bone) and surgical repair. The physician's history and physical, dated 12/3/14, revealed that R5 had "significant dementia" (an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities).</p> <p>R5's MDS assessment, dated 12/27/14, revealed that R5's memory and thinking was impaired and required the assistance of one staff person for routine care, which included dressing, personal hygiene and bathing.</p> <p>On 12/1/14, R5 was care planned for at risk for falls with an intervention that included to "report development of ... bruises ...". In addition, R5 was care planned related to impaired mobility on 12/2/14 with an intervention that included to "report changes in skin integrity found during daily care".</p> <p>Review of R5's clinical record, from 1/22/15</p>	F 309	<p>be conducted bi-weekly for four weeks.</p> <p>The Administrative Director of Nursing Services and or Designee will audit initial skin sweeps bi-weekly skin sweeps x2</p> <p>The Administrative Director of Nursing Services and or Designee will audit that new bruises/skin alterations have an incident report completed and that the physician and family were notified. <i>attach next</i></p> <p>The Staff Development Coordinator and or Designee provided one on one in-service to the nurses involved.</p> <p>The Staff Development Coordinator and or Designee will in-service the nursing staff on:</p> <ul style="list-style-type: none"> properly completing an incident report for bruises/skin alterations documenting bruises/skin alterations in the clinical record expectations of weekly body audits (on shower days) by licensed nurse to include identification of bruises/skin alterations notifying the physician and family when a new bruise/skin alteration is identified 	<p>6/16/15</p> <p>6/16/15</p>	

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

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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)	(X5) COMPLETION DATE
F 309	<p>Continued From page 14</p> <p>through 1/29/15, revealed that R5 was showered once and had one "body audit" (assessment of her skin) by a licensed nurse. In addition, R5 required assistance of one staff person for routine care, which included dressing and personal hygiene in the morning, evening and as needed. During this timeframe, R5's clinical record lacked evidence of bruising on her bilateral upper arms.</p> <p>A nurse's note, dated 1/29/15 at 10:55 AM, stated, "... resident will not straighten her left leg at all ... c/o (complaint of) of pain to the hip area, call put out to md (medical doctor)".</p> <p>A nurse's note, dated 1/29/15 at 1:21 PM, stated, "... send resident to the er ... unable to straighten left leg...".</p> <p>The facility's acute care transfer form, dated 1/29/15 and timed 1:23 PM, stated that this was an unplanned transfer and noted R5 to have "... severe pain ... resident wont (sic) bend left leg ...". R5 left the facility by ambulance at 1:39 PM.</p> <p>Review of the emergency room's documentation including photographs, dated 1/29/15 at 3:55 PM, identified that R5 had bruising on both her left and right upper arms. Specifically, R5's left upper arm exhibited a bruise measuring 10 cm x (by) 5 cm with colors that included purple, red, yellow and green. R5's right upper arm exhibited a bruise measuring 6 cm x 14 cm with colors that included purple, red and yellow.</p> <p>According to a nurse's note, dated 1/29/15 at 7:30 PM, R5 returned to the facility approximately 5 hours later.</p> <p>Review of R5's clinical record upon her return to</p>	F 309	<p>The Administrative Director of Nursing Services and or Designee will conduct audits that nursing is:</p> <ul style="list-style-type: none"> • completing incident report was properly • bruises/skin alterations are documented in the clinical record • weekly body audits on shower days are completed accurately • the physician and family are notified of new bruising or skin alterations <p>This will be monitored 3 X a week until we reach 100% compliance over 3 consecutive evaluations</p> <p>Then will monitor weekly until we consistently reach 100% compliance over three consecutive evaluations.</p> <p>Finally the Administrative Director of Nursing Services and or Designee will monitor one more time a month later, if 100%</p> <p><i>Attachment</i></p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans</p>	<p>6/16/15</p> <p>6/16/15</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5851 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 309	<p>Continued From page 15</p> <p>the facility from the ER on 1/29/15 lacked evidence of the identified bruises on her bilateral upper arms. It is unclear in the record how these bruises were never identified prior to transfer to the emergency room and upon her return to the facility as R5 required the assistance of one staff person for routine care, including dressing, personal hygiene and bathing. In addition, R5 was ordered to have a "body audit" performed by a licensed nurse every Saturday evening. The clinical record lacked evidence that the "body audit" performed by the licensed nurse on 1/31/15 identified the bruises.</p> <p>In an interview on 3/27/15 at 11:35 AM, E5 (CNA) stated that she did not remember any bruising on R5. E5 stated that when she provided routine hygiene care to R5, she would give a wash cloth to R5 to wash her face, but E5 would provide hygiene care from her neck down to her feet. E5 also stated that when a resident was showered, the assigned CNA would fill out a facility form entitled, "Skin Worksheet" and give it to the assigned nurse to sign off. According to the facility's 1/2013 "Skin Practice Guide", the Skin Worksheet was "a communication tool and ... not maintained as part of the clinical record".</p> <p>In an interview on 3/27/15 at 2:10 PM, E1 (NHA), E2 (DON) and E3 (Regional Nurse) were shown the photographs taken of R5's bruised bilateral upper arms on 1/29/15 at the emergency room. It was at this time that the facility became aware of R5's bruises to her bilateral upper arms on 1/29/15. E2 and E3 stated that the facility does not have a policy to assess the resident's skin prior to and return from the emergency room if the resident returns to the facility within 24 hours.</p>	F 309	<p>2. R6 no longer resides in the facility.</p> <p>The Administrative Director of Nursing and or Designee will do daily observation audits:</p> <ul style="list-style-type: none"> of all resident's with IV fluids/medications to confirm that the physician's written order matches the IV fluid/medication that is hanging that medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to licensed nursing staff and maintained under a locked system when not actively utilized and no medications are left at bedside unless the resident has physician's order to self-administer. Medication pass observation to audit the 6 Rights of Medication administration are being followed <i>attachment</i> <p>The staff Coordinator and or Designee will in-service on:</p> <ul style="list-style-type: none"> The 6 rights of medication administration including IV fluids/medications 	<p>4/16/15</p> <p>4/16/15</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 5861 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 309	<p>Continued From page 16</p> <p>In an interview on 3/27/15 at 4:00 PM, E6 (LPN) stated that a body audit involves removal of all the resident's clothing to check skin and she would document any skin alteration, including bruises. It is unclear why facility documentation and the skin body audit failed to identify the bruises.</p> <p>Findings were reviewed during the exit conference with E1 and E2 on 1/31/15 at approximately 4:30 PM. The facility failed to identify bruises on R6's bilateral upper arms during multiple opportunities prior to and upon return from an emergency room visit on 1/29/15.</p> <p>2. R6 was admitted to the facility with diagnoses which included Aspiration Pneumonia (inhalation of food, drink, vomit or saliva into your lungs if something disturbs your normal gag reflex such as a brain injury or swallowing problem) and Hyponatremia.</p> <p>According to R6's 14 day admission MDS, dated 8/1/14, R6 needed extensive assistance of 1-2 staff for all of his ADLs. His skills for daily decision making were independent.</p> <p>On 10/1/14, E17 (NP) saw R6 for complaints of very poor appetite, feels weak, and weight loss. On 10/1/14, E17 gave an order for "D5W ... for poor oral intake and Hyponatremia". E7 (LPN) received the order as indicated by her signature on the Physician's Order Form. The order was transcribed onto the MAR as "I.V. D5W ... started 10/1/14 at 1400 (2:00 PM) every shift for poor</p>	F 309	<ul style="list-style-type: none"> That medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to licensed nursing staff and maintained under a locked system when not actively utilized and that medications will not be left at bedside unless the resident has a physician's order to self-administer <p>The Administrative Director of Nursing Services and or Designee will monitor weekly x 3 the following:</p> <ul style="list-style-type: none"> of all resident's with IV fluids/medications to confirm that the physician's written order matches the IV fluid/medication that is hanging that medications are securely stored in a locked cabinet, cart, or locked medication room accessible only to 	<p>6/16/15</p> <p>6/16/15</p>
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 6651 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 309	<p>Continued From page 17</p> <p>intake and hyponatremia (sic) ...". E7 followed this occurrence with a nurse's note dated 10/1/14 at 14:45 (2:45 PM) that stated, "Pt. (patient) seen by ...NP (E17) this shift with new orders for I.V. D5NS ...". Review of the physician's order sheet revealed that there was no new order for I.V. D5NS. The most recent order received by E7 on 10/1/14 was written as D5W which had been recorded on the MAR as started at 2:00 PM the same day.</p> <p>Additionally, the facility's care plan that was initiated on 7/21/14 was revised on 10/2/14 for "Risk for alteration in hydration;... edema (swelling) and antibiotic treatment;... to include "hyponatremia, ...". The care plan goal included, "Maintain adequate hydration (water)" " IV D5W ...".</p> <p>The interventions included: Administer Medication per physician orders; Report changes related to signs of fluid deficits; Report any new onset or changes in edema level and Report changes to any signs of fluid overload such as SOB (shortness of breath) and obtain weights as ordered/indicated and observe changes.</p> <p>According to the same 10/14 MAR flow sheet, E8 (LPN) on 10/1/2014 at 2:45 PM, E9 (RN) on 10/1/14 at 10:45 PM and E10 (RN) on 10/2/14 at 6:45 AM, signed off with a check mark that R6 was receiving IV fluids. However, none of them had identified the IV bag's label and verified it with the physician's order on the MAR.</p> <p>E11 (RN/DCD) wrote a late entry note, dated 10/02/14 which stated, "On 10/2/14 at approx. (approximately) 7:30 AM the patient and nurse practitioner were notified that D5NS was infusing</p>	F 309	<p>licensed nursing staff and maintained under a locked system when not actively utilized and no medications are left at bedside unless the resident has physician's order to self-administer.</p> <ul style="list-style-type: none"> Medication pass observation to audit the 6 Rights of Medication administration are being followed weekly x 3 Until we consistently reach 100% compliance over three consecutive evaluations Then will monitor monthly x2 until we consistently reach 100% compliance over 3 consecutive evaluations <p>Finally the facility will monitor one more time one month later. If 100% compliance, will no longer monitor.</p> <p><i>attachment</i></p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans</p> <p>3. SS2 no longer resides in the facility.</p>	<p>6/16/15</p> <p>6/16/15</p>

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 6651 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 309	<p>Continued From page 18 instead of D5W ... The nurse practitioner ordered follow-up blood work and to "continue with D5W at 50 cc/hr".</p> <p>An incident report was written on 10/2/14 at 7 AM, that stated, "D5W ordered, D5NSS running at the time. Two hundred fifty (250 cc) remaining from the 1000cc bag (750 cc was infused in 17 hours)."</p> <p>During the facility's investigation of the incident, statements were taken from E8, E9, and E10 and stated that they had signed off on the MAR to indicate that R6 was receiving IV fluids. However, they failed to verify that the IV fluid hanging was not correct.</p> <p>In an interview, on 3/26/15 at approximately 1:30 PM, E11 brought out 2 bags of the IV solution (D5W and D5NSS) and identified to the surveyor that the D5NSS solution was the one discovered hanging, that E7 hung at 2 PM on 10/1/14, instead of the D5W as ordered.</p> <p>This finding was discussed with E1, E2, and E3 on 3/25/15 at approximately 11:30 AM and confirmed. The surveyor was provided copies of Nursing Staff attendance sign-up sheet of the facility's series of in-service on IV fluids and the 6 Rights of Medication Administration that they provided from 10/11/14 through 12/13/14.</p> <p>3. Review of SS2's March 2015's Order Summary Report revealed a doctor's order, dated 3/2/15 that stated, "Vitamin D3 Tablet 1000 unit (Cholecalciferol/a compound occurring naturally in milk and fish-liver oils, essential for the formation of normal bones and teeth). Give 5000</p>	F 309	<ul style="list-style-type: none"> The Administrative Director of Nursing Services and or Designee will audit: Medication pass observation to audit the 6 Rights of Medication administration is being followed (specifically the right dose). <p>The Staff Development Coordinator and or Designee will in-service nursing staff on:</p> <ul style="list-style-type: none"> The 6 rights of medication administration (Specifically the right dose) <p>The Administrative Director of Nursing Services and or Designee will monitor 3 X a week that the 6 rights of Medication Administration are being followed until we consistently reach 100% compliance of three consecutive evaluations.</p> <p>Then will monitor weekly until we consistently reach 100% compliance over three consecutive evaluations.</p> <p>Finally the Administrative Director of Nursing Services and or Designee will monitor one more time a month later, if 100% compliance then we will no longer monitor.</p>	6/6/15 6/16/15	

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

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FORM APPROVED
OMB NO. 0938-0391

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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)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 19 unit by mouth in the morning for supplement".</p> <p>Review of the facility's policy, dated 12/2014 and entitled, "Medication and Treatment Administration Guidelines" stated, "... Medication Administration: Medications are administered in accordance with the following "rights" of medication administration ... right dose...".</p> <p>During the medication observation pass on 3/31/15 at approximately 7:35 AM, E14 (RN) prepared SS2's medications prior to administration. E14 poured only 1 tablet (1000 unit) of the Vitamin D3 and continued pouring SS2's other medications. She locked up her medication cart and was leaving the cart to go and administer SS2's medications, when she was stopped by the surveyor and asked to reexamine the Vitamin D3. E14 stated, "Vitamin D3 (1000 Unit)" reading the label on the bottle, and was then asked to read the resident's doctor's order. E14 read, "...5000 units". The surveyor asked E14 how many pills did she dispense in the medicine cup. E14 looked in the medicine cup and said, "one... that's what is supposed to be there, one". E14 was then instructed to reread the doctor's order and asked how much did she dispense. She looked in the cup again and said, "Oh, my mistake ... the bottle must have been changed because the other bottle only needed 1 pill ...". E14 confirmed that she would have administered the wrong dose, only 1,000 units (1 tablet) instead of the 5,000 units (5 tablets) that were prescribed, had the surveyor not stopped her.</p> <p>Findings were reviewed during the exit meeting with E1 and E2 on 3/31/15 at approximately 4:35 PM.</p>	F 309	<p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.</p> <p>4. R7 no longer resides in the facility</p> <p>An initial audit of all resident's charts were completed to review that the allergies list is update and accurate.</p> <ul style="list-style-type: none"> The Administrative Director of Nursing Services and or Designee will audit residents chart to review that the allergy list is updated and accurate when a new medication is ordered and care plan reflects this. <p>The Staff Development Coordinator and or Designee will in-service nursing to first check allergy list prior to administration of a new medication, to avoid risk of complication from a medication allergy.</p> <p><i>attachment</i></p>	6/6/15 6/16/15	

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

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5881 LIMESTONE ROAD WILMINGTON, DE 19808		
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F 309	Continued From page 20 4. Review of R7's clinical record revealed that an allergy to the medication, Bactrim (a sulfa antibiotic used to treat infection) was noted on 10/18/2014 at 11:18 AM. According to the "Order Summary Report" (physician order form) dated 10/01/2014 - 10/31/2014, R7 was prescribed "Bactrim DS (Double Strength) Tablet 800-160 mg, Give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days" by phone on 10/17/2014. Review of the eMAR, dated 10/01/2014 - 10/31/2014, also revealed that R7 was administered a single dosage of the medication, Bactrim DS Tablet 800-160 mg, 1 tablet by mouth at 8 PM on 10/17/2014. Although the eMAR, dated 10/01/2014 - 10/31/2014, also included a list of drug allergies, R7's allergy to sulfa was identified in the care plan. A nurse's note, dated 10/17/2014 and timed 3:41 PM, revealed Bactrim DS, 1 tablet by mouth twice a day for seven days was ordered and transcribed to R7's eMAR dated 10/01/2014 - 10/31/2014. However a nurse's note, dated 10/18/2014 and timed 11:18 AM, revealed that the order for Bactrim DS was discontinued upon notification of the physician of R7's allergy to the medication. Discontinuation of the medication, Bactrim DS, after the administration of one dose was also reflected on the "Order Summary Report" and the eMAR, each dated 10/01/2014 - 10/31/2014. Review of the care plan developed initially on 5/20/2011 to address "At risk for complications r/t (related to) allergy to medication..." revealed that the facility failed to implement interventions and	F 309	* Then the Administrative Director of Nursing Services and or Designee will monitor 3 x weekly all new admissions allergies are updated and accurate until we consistently reach 100 % compliance. Then will monitor weekly until we consistently reach 100% compliance over three consecutive evaluations Finally, will monitor one more time a month later, if 100% compliance then we will no longer monitor. <i>attachment</i> Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.	6/16/15 6/16/15	

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

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OMB NO. 0938-0391

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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)	(X5) COMPLETION DATE
F 309	Continued From page 21 avoid the risk of complications from a medication allergy and to ensure that checks were performed against allergies prior to the administration of new medication orders.	F 309	<p>F425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH</p> <p>It is the practice of the facility to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement.</p> <p>The facility does provide pharmaceutical services (including procedure that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents.</p> <p>The facility does employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Cross reference F309 example #4</p> <p>4. R7 no longer resides in the facility</p> <p>An initial audit of all resident's charts were completed to review that the allergies list is update w and accurate.</p>	
F 425 SS=D	<p>These findings were reviewed with E1 and E2 on 3/18/2015 at approximately 4:35PM.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, it was determined that the facility failed to ensure the accurate dispensing and administering of pharmaceutical services for one resident (R7) out</p>	F 425		

6/6/15

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

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F 425	Continued From page 22 of eight sampled residents. Findings include: Cross refer F309, example #4. Review of the clinical record revealed that a nurse's note, dated 10/18/2014 and timed 11:18 AM, revealed that Bactrim (a sulfa antibiotic used to treat infection) was discontinued because of R7's allergy to the medication. R7 received one dose of the ordered medication, Bactrim DS, 1 tablet by mouth ... to treat a UTI (urinary tract infection) as prescribed by her physician on 10/17/2014 at 8:00 PM. Although R7's drug allergies were listed on the physician "Order Summary Report" dated 10/01/2014 - 10/31/2014 and the eMAR dated October 1, 2014 - October 31, 2014, each was absent R7's allergy to sulfa medications as identified in the care plan. The facility in conjunction with pharmacy services failed to check all allergies listed for R7 prior to the dispensing and administration of a medication. These findings were reviewed with E1 [NMA] and E2 [DON] on 3/18/2015 at approximately 4:35PM.	F 425	<ul style="list-style-type: none"> The Administrative Director of Nursing Services and or Designee will audit residents chart to review that the allergy list is updated and accurate when a new medication is ordered and care plan reflects this. <p><i>attach meet</i></p> <p>The Staff Development Coordinator and or Designee will in-service nursing to first check allergy list prior to administration of a new medication, to avoid risk of complication from a medication allergy.</p> <ul style="list-style-type: none"> Then the Administrative Director of Nursing Services and or Designee will monitor 3 x weekly all new admissions allergies are updated and accurate until we consistently reach 100% compliance. <p>Then will monitor weekly until we consistently reach 100% compliance over three consecutive evaluations</p> <p>Finally, will monitor one more time a month later, if 100% compliance then we will no longer monitor. <i>attach met</i></p>	4/6/15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		4/6/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 23 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, facility documentation, and interviews, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the potential development and transmission of disease and infection related to hand washing technique and cleaning of resident equipment for three (3) (SS3, SS4 and SS6) out of six (6) sub sampled residents. Findings include:</p>	F 441	<p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.</p> <p>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>It is the practice of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Staff are washing SS3 hands after providing care SS6 and SS4 no longer reside in the facility.</p> <p>The the Administrative Director of Nursing Services and or Designee will do daily observations audits of:</p> <ol style="list-style-type: none"> Nurses during their medication pass and while providing care to evaluate if the nurse is washing their hands after providing care or administering medications 	<p>6/16/15</p> <p>6/11/15</p>

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F 441	<p>Continued From page 24</p> <p>1. During the medication pass observation, on 3/31/15 at approximately 9:00 AM, E18 (RN Supervisor) failed to wash her hands after providing care to SS3 and before providing care to SS4. E18 had handled their identification bands and medications, posing a potential for cross-contamination/infection from one resident to another.</p> <p>Review of the facility's policy, dated 12/2009 and entitled, "Hand Hygiene" stated, "Purpose: To decrease spread of infection ... When to wash hands: ... After having direct contact with patient's intact skin (... when taking pulse or blood pressure ...) if hands are not visibly contaminated ... After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient..."</p> <p>During an interview on 3/31/15 at 8:30 AM, E18 confirmed the findings. The facility failed to ensure hand washing between residents was provided as per their policy.</p> <p>Findings were reviewed during the exit meeting with E1 (NHA) and E2 (DON) on 3/31/15 at approximately 4:35 PM.</p> <p>2. After using the Dinamapp machine (portable electronic machine/used to take pulse and blood pressure) on 3/31/14 at approximately 8:25 AM for SS4, E18 failed to disinfect reusable equipment (blood pressure cuff) between patients.</p> <p>During an interview on 3/31/15 at 8:30 AM, E18 confirmed that she failed to clean the reusable blood pressure cuff after taking SS4's blood</p>	F 441	<p>2. Cleaning and disinfect equipment in between residents such blood pressure cuff, Dinamaps</p> <p>3. Anything found on floor such as a call bell must be disinfected before putting it back.</p> <p><i>attachment</i></p> <p>The Staff Development Coordinator and or Designee will in-service nursing on</p> <p>Infection Control Program, to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility Infection control policy.</p> <p>1. Employees must wash their Hands after providing Care.</p> <p>2. Employees must Clean and disinfect equipment in between residents such blood pressure cuff, Dinamaps</p> <p>3. Anything found on floor such as a call bell must be disinfected before putting it back.</p>	<p>6/6/15</p> <p>6/6/15</p>	

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F 441	<p>Continued From page 25</p> <p>pressure. She stated, "In the year and a half that I've been here, we (staff) don't use anything to clean the blood pressure cuff". E18 denied knowledge of any policy that covered cleaning/disinfecting reusable equipment shared between patients. E18 left to consult with E11 (RN/DCD).</p> <p>On 3/31/15 at 8:33 AM, E11 was observed looking through a binder of policy guidelines and was asked by the surveyor if the blood pressure cuff was supposed to be cleaned between resident use. E11 stated, "I don't know... I'm looking it up now in the policy book".</p> <p>Review of the facility's policy, dated 5/2013 and entitled, "Infection Control Manual: ... Practice Guidelines Standard Precautions" stated, "... Patient Care Equipment ... Disinfect reusable equipment between patients (... blood pressure cuffs ...) with an EPA (Environmental Protection Agency/federal agency)-registered disinfectant or hypochlorite (bleach) solution ... Clean and disinfect surfaces that are likely to be contaminated ... and frequently touched surfaces in the patient care environment ...".</p> <p>When interviewed, neither E18 nor E11 could explain the procedure for cleaning reusable equipment between residents. Findings were confirmed by E11 when he provided a copy of the facility's policy to the survey team on 3/31/15.</p> <p>Findings were reviewed during the exit meeting with E1 and E2 on 3/31/15 at approximately 4:35 PM.</p> <p>3. During the medication pass observation, on 3/31/15 at approximately 9:05 AM, S36 was</p>	F 441	<p>Then the Administrative Director of Nursing Services and or Designee will monitor weekly:</p> <ol style="list-style-type: none"> 1. The nurses while providing care to residents are washing their hands in-between residents, 2. Disinfecting equipment in between residents, 3. If anything is on the floor it must be disinfected prior to being put back <p>Until we consistently reach 100 % compliance over 3 consecutive evaluations.</p> <p>Then will monitor monthly until we consistently reach 100% compliance over three consecutive evaluations</p> <p>Finally, will monitor one more time a month later, if 100% compliance then we will no longer monitor.</p> <p><i>Attachment</i></p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.</p>	<p>6/6/15</p> <p>6/16/15</p>

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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	
F 441	Continued From page 26 observed out of bed, in her wheelchair facing the foot of her bed. E7 (LPN) noticed that there was no call bell within SS6's reach. E7 searched and found SS6's call bell, on the dirty, dusty floor behind the head of the resident's bed. E7 picked up the call bell and clipped it to SS6's clean, crisp linens in order to place it within the resident's reach. E7 failed to clean the call bell prior to clipping it to SS6's clean linens. Review of the facility's policy, dated 8/2013 and entitled, "Infection Control Manual: ... Practice Guidelines Standard Precautions" stated, "... Patient Care Equipment ... Clean and disinfect surfaces that are likely to be contaminated ... and frequently touched surfaces in the patient care environment ...". During an interview, immediately following this observation, E7 confirmed the findings. She cleaned the call bell and removed SS6's bed linens. Findings were reviewed during the exit meeting with E1 and E2 on 3/31/15 at approximately 4:35 PM.	F 441			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide or	F 502	F 502 ADMINISTRATION It is the facility practice to provide or obtain laboratory services to meet the need of its residents. The facility is responsible for the quality and timeliness of services. R 3 still resides in the facility her medical record was reviewed and her labs accurately reflect the physicians orders. The lab was obtained on February 2, 2015 all with in normal limits	6/6/15	

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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)	(X5) COMPLETION DATE	
F 502	Continued From page 27 obtain laboratory services to meet the needs of its residents, including the timeliness of services for one (R3) out of 8 sampled residents. Findings include: R3 was originally admitted to the facility on 3/23/07. R3 had diagnoses that included hyposmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal)/hyponatremia (low blood sodium) and hypertension (high blood pressure). R3's ordered medications included Hydrochlorothiazide (diuretic/water pill, used to treat hypertension and edema/swelling) 12.5 mg by mouth one time a day. R3 had a doctor's order, dated 7/2/14, and timed 4:23 PM, that stated, "BMP (basic metabolic panel/blood test-set of eight tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balances) every 6 months (March, Sept/September) every night shift every 6 month(s) starting on the 1st for 1 day(s)". Review of R3's care plan, dated 3/20/07 and entitled, "At risk for adverse effects related to diuretic therapy" included the intervention, "...Monitor electrolytes/renal (kidney) function as ordered. Notify physician if abnormal result...". Review of R3's record lacked evidence that a BMP was drawn in September 2014. During an interview on 3/31/15 at approximately 10 AM, E16 (RN/DCD) confirmed the finding. The facility failed to obtain laboratory services (BMP) for R3 in September 2014 as per the doctor's order and the plan of care.	F 502	An initial audit of all residents orders Q 6 months and annually will be reviewed Then the Administrative Director of Nursing Services and or Designee will audit all residents with routine labs ordered Q6 months and annually to evaluate that the resident did receive their routine labs per physician's orders. They will also audit days that the lab is closes to se that the lab was rescheduled for the next day the lab is open. <i>Attachment</i> The Staff Development Coordinator and or Designee will in-service nursing on routine labs ordered Q6 months and annually to evaluate that the resident did receive their routine labs per physician's orders. Also days that the lab is closed (i.e. Holidays) to make sure that the lab was rescheduled for the next day the lab is open.	6/6/15 6/6/15	

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

PRINTED: 04/24/2015
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 04/15/2015
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 502	Continued From page 28 Findings were reviewed during the exit meeting with E1 (NHA) and E2 (DON) on 3/31/15 at approximately 4:35 PM.	F 502	<p>Then the Administrative Director of Nursing Services and or Designee will monitor all residents with routine labs ordered Q6 months and annually to evaluate that the resident did receive their routine labs per physicians order.</p> <p>This will be monitored weekly until we reach 100% compliance over 3 consecutive evaluation.</p> <p>Then will monitor monthly until we consistently reach 100% compliance over three consecutive evaluations</p> <p>Finally the Administrative Director of Nursing Services and or Designee will monitor one more time a month later, if 100% compliance then we will no longer monitor. <i>attachment</i></p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.</p>	<p>6/6/15</p> <p>6/6/15</p>



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-8661

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Pike Creek

DATE SURVEY COMPLETED: April 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from March 24, 2015 and ended on April 15, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of facility and other documentation as indicated. The facility census on the first day of the survey was 167. The survey sample included (8) sampled residents and (6) sub sampled residents.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p>		<p>6/6/15</p>

Provider's Signature  Title LWHA Date 5/7/15



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NAME OF FACILITY: Manor Care Health Services Pike Creek

DATE SURVEY COMPLETED: April 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.9.0	<p>This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey exit date April 15, 2015 citations F157, F246, F278, F281, F309, F425, F441 and F502.</p> <p>Records and Reports</p>	<p>Cross refer to CMS 2567-L survey exit date April 15th, 2015 citations F157, F246, F278, F281, F309, F425, D441 and F502</p>	6/6/15
3201.9.5	<p>Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; the resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.</p>	<p>R7's medical records were reviewed and allergies were updated to accurately reflect current allergies.</p>	
3201.9.7	<p>Incident reports which shall be retained in facility files are as follows:</p>	<p>An initial audit of all resident's charts were completed to review that the allergies list is update and accurate. During this audit no medication errors were identified. . There were no medication errors identified during the audit.</p>	
3201.9.7.3	<p>Errors or omissions in treatment or medication.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to complete and retain an</p>	<p>The Administrative Director of Nursing Services and or Designee will audit residents chart to review that the allergy list is updated and accurate when a new medication is ordered and care plan reflects this.</p>	

Provider's Signature *Mary Ellen B* Title *LN/A* Date *5/7/15*



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STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Pike Creek

DATE SURVEY COMPLETED: April 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>incident report of a medication error that involved one resident (R7) out of eight sampled. Findings include:</p> <p>Clinical record review revealed R7 had diagnoses that included urinary tract infection. Further review of the clinical record revealed that R7 received a new order for Bactrim DS (a sulfa antibiotic used to treat infection) for a urinary tract infection. Although the clinical record revealed that drug allergies for R7 were listed on the eMARs dated 10/01/2014 – 10/31/2014, the "Order Summary Report" (physician order form), dated 10/01/2014 – 10/31/2014, the progress notes and the care plan, R7 received one tablet of the medication, Bactrim DS, by mouth at 8:00 PM on 10/17/2014. According to a nurse's note dated 10/18/2014 and timed 11:18 AM the physician was notified and discontinued the medication, Bactrim DS, and ordered another antibiotic to treat R7's urinary tract infection.</p> <p>Additionally the facility was unable to provide a complete written report including an investigation of the medication error that occurred at 8:00 PM on 10/17/2014. In an interview conducted with E2 (DON) on 3/31/3015 at 11:56 PM it was stated that a report of this medication error was not available. The facility guidelines, "Medication Management Guidelines: Errors", states "...complete the Incident Report and the Occurrence Investigation Report, as outlined in the Quality Assessment and Assurance manual...".</p>	<p>The Staff Development Coordinator and or Designee will in-service nursing to first check allergy list prior to administration of a new medication, to avoid risk of complication from a medication allergy.</p> <p>If a medication error does occur the nurse must complete an incident report and notify the physician and family.</p> <ul style="list-style-type: none"> Then the Administrative Director of Nursing Services and or Designee will monitor 3 x weekly all new admissions allergies are updated and accurate when a new and the care plan reflects this. If medication error is identified that an incident report was completed, the physician and the family notified until we consistently reach 100 % compliance. 	<p>6/6/15</p>

Provider's Signature *May Kelley* Title LN Hr Date 5/7/15



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Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Pike Creek

DATE SURVEY COMPLETED: April 15, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>These findings were reviewed with E1 (NHA) and E2 on 3/18/2015 at approximately 4:35 PM.</p>	<p>Then will monitor weekly until we consistently reach 100% compliance over three consecutive evaluations</p> <p>Finally, will monitor one more time a month later, if 100% compliance then we will no longer monitor.</p> <p>Quality Assurance Committee initiated a Performance Improvement Plan (PIP). Results of the audits will be submitted to the QAA committee for review and action as appropriate. The QAA committee will determine the need for further audits and/or action plans.</p>	<p>6/6/15</p>

Provider's Signature  Title LNA Date 5/7/15