

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

PRINTED: 07/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966
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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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INITIAL COMMENTS

An unannounced annual survey was conducted at this facility from July 9, 2015 through July 20, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 157. The stage two survey sample was forty two (42).

Abbreviations/Definitions used in this 2567 are as follows:
 NHA- Nursing Home Administrator;
 DON - Director of Nursing;
 RN - Registered Nurse;
 LPN - Licensed Practical Nurse;
 UM - Unit Manager;
 MD - Medical Doctor;
 RNAC - Registered Nurse Assessment Coordinator;
 MOS - Minimum Data Set (standardized assessment forms used in nursing homes);
 CNA - Certified Nurse's Aide;
 FSD - Food Service Director;
 RD - Registered Dietitian;
 NP - Nurse Practitioner;
 ADLs - Activities of Daily Living, such as bathing and dressing;
 cm - centimeter, unit of length;
 Antidepressant-drug used to treat depression;
 Antipsychotic-medication used to treat mental conditions;
 Antihypertensive-drugs used to treat high blood pressure;
 Dementia-loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
 ER-Emergency room;

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The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 9/01/15.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>NHA (John R. Bear)</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/7/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 F - degrees Fahrenheit; PRN - As needed; MAR - Medication Administration Record; Narcotic-an addictive drug that relieves pain; Continenence - control of bladder and/or bowel function; Incontinence - loss of control of bladder and/or bowel function; Always incontinent-no episodes of continent voiding; Frequently incontinent - 7 or more episodes of urinary incontinence per week with at least 1 episode of continent urinary voiding; Occasionally incontinent - less than 7 episodes of urinary incontinence per week; UTI-urinary tract infection-bacteria in the urine; Voiding diary (Three Day Voiding and Defecation Diary) - log completed every hour for three days of how much the resident voided and the number of incontinent episodes; Unstageable - tissue loss in which the actual depth of the ulcer is unable to be determined; Pressure ulcer -sore area of skin that develops when blood supply to it is cut off due to pressure, laying/sitting on it; Slough -yellow, tan, gray, green or brown dead tissue; Depression -mental disorder with feelings of sadness.	F 000		
F 164 SS= D	483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	(F164) A. Individual / Resident Impacted There was no negative outcome to residents R62 and R352. E7 and E 20 were in-serviced by DON/ Staff educator on Resident Rights and Privacy.	

STATE SURVEY DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING - B. WING -	(X3) DATE SURVEY COMPLETED 07/20/2015
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164

Continued From page 2
communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that the facility failed to deliver care in a manner that respected resident privacy for two (R352 and R62) out of 42 sampled residents. Findings include:

1. On 7/13/15 at 9:46 AM E7, NP, was observed walking into room 705 when the door was closed. E7 did not knock nor ask permission to enter, he entered the room and walked toward the bed. When E7 saw R352 engaged in an interview with state survey staff and 2 other visitors he turned around and left without saying a word.

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164

B. Identification of other residents
All residents residing at Atlantic Shores will be protected from staff violating right to privacy and confidentiality.

C. System Changes
Staff at Atlantic shores including contracted staff will be in-serviced on resident rights regarding personal privacy and confidentiality. All new hires will be in-serviced during orientation.

D. Success Evaluation
Random inspections and rounds will be conducted through the ambassador program weekly. This will be monitored weekly until achieving 100% for 3 consecutive weeks, and then will be monitored monthly times two months. Findings will be reviewed during the QAPI Committee meeting monthly.

9/1/2015

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F 164 Continued From page 3
These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 (NHA), and E2 (DON).
2. On 7/9/15 at 9:55 AM E20 LPN, during a medication administration observation for R62, entered the bathroom to wash her hands, while another resident, R36, was in the bathroom on the toilet. E20 knocked but did not ask permission nor wait for permission to enter the bathroom from R36. Following administration of eye drops to R62, at 10:00 AM, E20 entered the bathroom again, while R36 was still sitting on the toilet, and E20 washed her hands.

During an interview on 7/17/15 at 2:04 PM with E20 and E5 RN, E20 confirmed that she entered the bathroom without permission, while R36 was using the toilet, and that handwashing could have been done in another sink to avoid disrupting R36's privacy.

E20 failed to ensure R36's right to privacy twice during medication administration observation to R62.

These findings were reviewed on 7/20/15 at approximately 2: 15 PM with E1, and E2.

F 164

F 242 SS= E 483.15(b) SELF-DETERMINATION- RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

F 242

A. Individual Residents Impacted
R320 was informed of her therapy schedule as soon as it was brought to the attention of the therapy dept on 7/14/2015. There was no negative out come due to this event.

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Conti-ued From page 4

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that the facility did not have a system in place to ensure residents knew their rehabilitation therapy schedule. Findings include:

During the stage 1 screening of the survey process residents' concerns about their therapy schedules were identified.

An interview on 7/14/15 at 9:55 AM with the Director of Therapy E19, revealed residents are scheduled for therapy based on the residents' activity level. Some residents like to do both therapy sessions in the morning, and some like one in the morning and one in the afternoon. E19 tries to get the schedule out by 3:00 PM the day before. It goes to the unit manager and the unit nurses. They either put in on the back of the closet door or in the therapy binder that is kept in the residents' room.

An interview on 7/14/15 at 10:08 AM with E5 Unit Manager revealed that therapy scheduling is done by the therapy department. She then called the therapy department and was told that the resident schedules should be in the therapy binders in the residents' rooms. The therapy binder in a random room (709 of a resident receiving therapy) was found in the bottom drawer of the night stand and did not contain a therapy schedule. During this observation E11 (CNA) approached and stated that a schedule used to be posted up near the nurses station but it was not always there anymore. The board was checked and found to have no schedule. E5 called the therapy department again for

F
242

B. Identification of Other Residents
All residents participating in the therapy program were given a therapy schedule. The therapy dept will provide a schedule to each rehab resident and the unit manager daily.

C. System Changes
A procedure was developed regarding therapy schedules for residents. Their schedules will be posted daily on a dry erase form in the resident room, and a copy provided to the unit manager. Nursing staff and therapy staff will be in-serviced on the process. All new hires will also be in-serviced on the rehab scheduling process for residents.

D. Success Evaluation
Therapy director and / designee will conduct a random audit to ensure compliance that the process is met. They will audit daily until 100% compliance is achieved times three weeks, and then audit weekly times two months. Ambassadors assigned to those rooms will also monitor to ensure compliance. Findings will be reviewed with the QAPI Committee meeting monthly.

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F 242 Continued From page 5 clarification.

An interview on 7/14/15 at 10:36 AM with ES and E19 revealed that over the past few weeks the therapy schedule has not been coming out as it should be. There was still confusion concerning where the schedule would be documented to provide easy access for the residents involved.

An interview on 7/14/15 at 11:29 AM with R320 revealed that she does not know what her therapy schedule is and she has to ask staff to find out the times. R320 was unaware of the use of a therapy binder.

The facility failed to ensure that residents receiving therapy services were aware of their specific therapy schedule.

These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.

F 242

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 the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation it was determined that the facility failed to provide a reasonable accommodation of individual needs by having the

F 246

A. Individual / Resident Impacted
R 201 was provided the call bell by the surveyor. The call bell was functioning.

B. Identification of Other Residents
All residents residing in Atlantic Shores Rehabilitation and Health Center will have Call bells easily accessible within their reach.

C. System Changes
Staff will be in-serviced to ensure call bells are always within the reach of residents. All new hires will also be in-serviced on the call bell accessibility and response during orientation.

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ATLANTIC SHORES REHABILITATION & HEALTH CENTER

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F 246 Continued From page 6
call bell within reach for one (R201) out of 42 sampled residents.

1. Observation on 7/15/15 at 10:37 AM revealed that the door to room 113 was cracked open and the resident (R201) was softly calling for help. The surveyor requested permission to enter. The resident verbalized that she needed assistance. When asked to ring her call bell she stated she did not have it. The call bell was located on the floor behind the bed. The resident was handed the call bell and then pressed the button.

2. On 7/20/15 at 8:30 AM R201 was sitting up in bed and her call bell was hanging from the upper left side rail out of reach from the resident.

The facility failed to provide one resident with consistent access to the call bell.

These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2: 15 PM.

F 253 SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that the facility failed to maintain housekeeping and maintenance services on three out of four units in the facility. Findings include:

F 246 D. Success Evaluation
Nursing staff will conduct a random audit daily times three weeks to ensure call bells are within reach, then weekly times two months. Findings will be reviewed with the QAPI monthly meeting.

9/1/2015

(F253)
A. Individual / Resident Impacted Station 1
Rooms 102 and 104 have been provided extended bed light cords for resident accessibility.

F 253 Room 109 drywall damaged has been repaired, and the bolt covers have been placed on toilet bolts.
Room 112 bathroom drywall damaged repaired.
Room 113 baseboards have been painted, extended light cords have been placed for both A and B beds, drywall damage has been repaired. Room provided new raised toilet seat.
Room 118 baseboards have been repainted.
Room 121 walls have received touch up painting.

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F 253

Continued From page 7
Observation during the environmental tour on 7/15/15 from 10:30 AM - 11:15 AM and again from 2:15 PM - 2:45 PM the following were observed:

Station 1 Beach Cove

- Room 102 both beds had over bed light cords that were too short;
- Room 104 over bed light cord short for bed 2 and had a bolt missing from the toilet;
- Room 109 drywall damage in the bathroom and no bolt covers on the toilet;
- Room 112 bathroom drywall damage, unpatched holes and trim damage;
- Room 113 base board trim scrapes, light cord too short for both beds, drywall damage near hand sanitizer dispenser and raised toilet seat rusted;
- Room 118 base board trim chipped;
- Room 121 wall scrapes and trim damage;
- Room 122 drywall damage around soap dispenser in the bathroom;
- Room 207 toilet bolts uncovered;
- Spa room with stains in the bathtub, nozzle and stopper corroded, debris and hair in the bathtub, heater unit rusted and inside panel of door very worn.

Station 2 Ocean Gardens

- Room 310 drywall damage near soap dispenser and urine odor in bathroom;
- Room 402 uncovered toilet bolts;
- Room 412 uncovered toilet bolts, base board trim damage and drywall damage near soap dispenser;
- Spa room bathtub dirty and stained, shower head dripping and would not turn off and two light

F 253 Room 122 drywall damaged has been repaired.
Room 207 has been provided covers for toilet bolts
Spa room tub has been re-glazed, heating unit has been refinished, and door was repainted and placed a plastic cover at bottom for future protection.

Station 2
Room 310 drywall damage repaired and bathroom cleaned
Room 402 cover for toilet bolts provided;
Room 412 cover for toilet bolts provided, base board trim repaired and drywall damage repaired;
Spa room bathtub re-glazed, shower head repaired for leak, and light bulbs replaced.

Station 3
Spa room bathtub re-glazed and nozzle and drain replaced

B. Identification of other Residents
A facility wide audit will be conducted during ambassador rounds to assure any / all areas in need of repair are noted and reported through the REQQER (electronic record maintenance system) system. All issues will be corrected timely.

C. System Changes
All staff ambassadors will be in-serviced to the new ambassador forms and the expectations of timely reporting of maintenance issues using the REQQER system. The Maintenance department will conduct preventative maintenance rounds covering one unit per week. All areas in need of repair will be corrected timely.

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F 253 Continued From page 8
bulbs were out.

Station 3 Bay Terrace

-Spa room bathtub stained with the interior peeling and chipped, nozzle and drain corroded.

These findings were reviewed with E17, Director of Maintenance on 7/17/15 at 11:30 AM. He revealed that staff are assigned rooms to do rounds in and these findings should be noted and sent to maintenance for repair.

F 256 SS=E 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS

The facility must provide adequate and comfortable lighting levels in all areas.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that the facility failed to provide adequate lighting for four [1208, 5108, 700A, 7028] out of 40 resident rooms reviewed. Findings include:

During Stage one initial observations on 7/8/15 and 7/9/15 and observation during the environmental tour on 7/15/15 from 10:30 AM - 11:15 AM and again from 2:15 PM - 2:45 PM the following rooms had no over the bed lights and the lamps on the bedside table did not light up;

1208, 5108, 700A, 7028

An interview on 7/15/15 at 2:40 PM with E18, Maintenance staff confirmed that the light in 5108

F 253 **D. Success Evaluation**
The Maintenance Director / designee will conduct weekly audits of REQQER requests and assure timely completion on maintenance related issues weekly for four weeks then monthly times two months. The Maintenance Director will reconcile REQQER requests with identified issues through ambassador rounds. Findings will be reviewed with the QAPI committee monthly.

F 256 (F256)
A. Individual / Resident Impacted
Rooms 120 B, 700 A, 510 B and 702 B have functional lamps that have been placed at bed side.

B. Identification of other Residents
All resident rooms will be checked to ensure adequate lighting is available.

C. System Changes
Staff will be in-serviced regarding the importance of adequate lighting available to all residents. New hires will be in serviced at orientation.

D. Success Evaluation
Maintenance Director / designee will conduct weekly rounds times 4 weeks and then monthly rounds times two months to ensure adequate lighting levels in all resident rooms. Ambassador's will also audit during regular ambassador rounds. Findings will be reported to the QAPI committee monthly.

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F 256 Continued From page 9
had a burned out bulb and was not plugged in. He stated he would check the above rooms to see why the lights were not working. E18 also revealed that the facility was only installing over the bed lights at resident request and that the bedside lamps had been provided to create a more home like environment.

F 256

These findings were reviewed with E17, Director of Maintenance on 7/17/15 at 11:30 AM.

F 279
SS=E 483.20(d), 483.20(k)(1)
DEVELOP COMPREHENSIVE CARE PLANS

F 279
(F279)

A. Individual / Resident Impacted
The facility recognizes that there is no corrective action that can be taken for R318 due to discharge status.

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

R354 was reassessed by Unit manager, voiding diary was initiated for three days. Individualized plan of care for incontinence care and management was developed to meet the needs to the resident.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The facility recognizes there is no corrective action for R54 due to discharge status.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.1 O(b)(4).

R201 was reassessed by IDT members, voiding diary was reinitiated. Individualized plan of care was developed.

R167 was assessed by IDT members and an individualized plan of care for depression was developed.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was

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F 279 Continued From page 10
determined that for 5 (R318, R354, R54, R201, R167) out of 42 sampled residents the facility failed to develop a care plan for an identified need. Findings include:

The facility policy entitled Care Plans - Comprehensive (last revised 8/2006) directs the facility to develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The resident's Comprehensive Care Plan is developed within seven days of the completion of the resident's comprehensive assessment (MDS).

The facility policy entitled Urinary and Bowel Incontinence-Evaluation and Management (undated) indicates a plan of care should be developed specifically to meet the resident toileting needs.

Cross refer to F315 example 2
1. Review of R318's clinical record revealed the following:

4/2/15- An admission MOS assessment indicated R318 was frequently incontinent of bladder.

6/15/15- A quarterly MOS assessment indicated R318 was always incontinent, no episodes of continent voiding.

Review of all of R318's care plans revealed in the risk for skin problems section created 3/30/15, with a goal of maintaining intact skin, the intervention to provide incontinence care after each incontinence episode and apply barrier cream as needed. There was no evidence

F 279 **B. Identification of Other Residents**
All residents will be assessed and medical records reviewed to ensure appropriate care plans are developed and revised quarterly and as needed. All new admissions and readmissions will be reviewed by the IDT members within 24 hours to implement interim care plans and update as needed. New residents comprehensive care plans will be developed within 7 days of the completion of the Residents Comprehensive Assessment (MDS).

C. System Changes
The interdisciplinary team will be re-serviced on care plan development and implementation. Policy and procedure for Care plan will be reviewed and revised as needed.

D. Success Evaluation
Unit Managers or designee will complete care plan audits of all new / readmission residents weekly times one month and monthly times two months. Findings will be reviewed by the QAPI Committee meeting monthly times three months.

9/1/2015

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F 279	<p>Continued From page 11</p> <p>provided of a care plan developed to address specific interventions related to the identified need of bladder incontinence.</p> <p>During an interview on 7/17/15 at 10:50 AM with EB unit manager it was confirmed that a care plan was not developed to address R318's bladder incontinence following either MDS assessment.</p> <p>These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 NHA, and E2 DON.</p> <p>2. R354 was admitted on 6/08/15. On 6/25/15 R354 was readmitted after a hospitalization.</p> <p>An admission MDS dated 6/11/15 assessed that R354 was frequently incontinent of urine.</p> <p>On 6/25/15 the resident was readmitted from a psychiatric hospital. The bladder function assessment was unchanged.</p> <p>On 7/3/15 the MDS states the resident is always incontinent and again on 7/14/15 states always incontinent.</p> <p>There was no care plan for urinary incontinence or bladder training despite the decline in R354's urinary status.</p> <p>The facility failed to develop a care plan addressing the resident's incontinence.</p> <p>These findings were reviewed with the E1 and E2 on 7/20/15 at 2:15 PM.</p> <p>3. R54 was admitted 2/1/15.</p>	F 279		
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Continued From page 12

The resident was sent to the hospital on 3/4/15 for lethargy, abnormal labs and a positive blood stool.

R54 was again readmitted on 3/10/15 from the hospital with a UTI, MI (heart attack), Hyperlipidemia (an abnormally high level of lipids in the blood), and internal bleeding. R54 had new orders to notify the physician for any parameters out of range, diminished breath sounds, new or worsening SOB (shortness of breath)/wheezing/chest tightness, inability to sleep without sitting up/needng two pillows/HOB (head of bed) elevated, deterioration in mental status or weight gain of 5 lbs. (pounds) in 3 days or 2 lbs. in 24 hours.

On 3/19/15 R54 was sent to the ER for evaluation related to changes in mental status. He returned from the hospital the next day with new orders for Lasix (a diuretic that removes fluids from the body). On 3/21/15 he was started on an antibiotic for a UTI.

On 4/13/15 The nurses note noted R54 to have fluid retention to his right lower extremity. His physician was made aware with new orders for an immediate test to rule out a blood clot.

On 04/14/15 The test results showed a blood clot to both legs and the physician was made aware. Resident was transferred to the hospital and had a filter placement to prevent further clotting of the blood.

On 04/17/15 The patient redeveloped diarrhea and was started on an antibiotic for C. diff

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F 279	<p>Continued From page 13 (bacterial overgrowth that releases toxins that attack the lining of the intestines).</p> <p>The facility failed to develop a care plan for the following changes in condition: 3/10/15 Internal bleeding; 3/19/15 ER visit for fluid retention with the (no update from 02/02/15) addition of a diuretic; 3/21/15 UTI; 4/14/15 Blood clots with filter placement; 4/17/15 Diarrhea/C. diff.</p> <p>These findings were reviewed with the E1 and E2 on 7/20/15 at 2:15 PM.</p> <p>Cross Reference F315, example #1 4. R201's admission nursing note on 1/14/15 at 8:10 PM by E12 (LPN) documented the resident was continent of urine.</p> <p>The 1/14/15 Bladder and Bowel Evaluation recorded a history of frequent urinary incontinence and that the resident was unaware of bladder urges. Mobility devices included walker, raised toilet seat and bed pan.</p> <p>The voiding diary dated 1/15/15 through 1/17/15 showed the resident was continent of urine with no episode of incontinence.</p> <p>MOS dated 1/21/15 (Admission 5-day) documented R201 was occasionally incontinent of urine and was not on a urinary training program. The resident required extensive assistance with one person for bed mobility, transfer and toilet use but believed to be capable of increased independence.</p>	F 279		
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Continued From page 14

F 279 A 1/22/15 progress note at 11:03 AM by E5 (Unit Manager) summarized the voiding diary to be "continent of urine".

Upon return from hospitalization at a psychiatric facility, R201's Bladder and Bowel Evaluation dated 4/10/15 at 3:11 PM by E6 (Unit Manager) documented frequent urinary incontinence with the resident unaware of bladder urges. Mobility devices included ambulatory, walker, raised toilet seat, bed pan, grab bars. Bladder summary was the resident was incontinent (initiate voiding diary). A voiding diary was not found in the clinical record.

On 4/10/15 E9 (Physician) ordered to apply house barrier cream to peri-area / buttocks after each incontinence episode and as needed to prevent skin breakdown.

On 4/17/15 the 5-day MOS stated the resident was frequently incontinent and was not on a urinary training program. Degree of assistance the resident needed was unchanged.

On 7/4/15 at 3:11 PM the quarterly Bladder and Bowel Evaluation stated that R201 was always incontinent of urine. Mobility devices included ambulatory and grab bars.

Care plan (Initiated 3/23/15, last revised 7/10/15) for the problem that Resident has unstageable pressure ulcer related to impaired mobility and nutritional status included an approach to provide incontinence care after each incontinence episode, apply barrier cream prn; avoid prolonged period of skin to skin contact. Problem for AOL Self Care Performance Deficit related to impaired balance did not include any interventions

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F 279	<p>Continued From page 15 addressing R201's urinary (bladder) incontinence.</p> <p>There was no evidence provided of a care plan developed to address specific interventions related to the identified need of bladder incontinence.</p> <p>E6 informed the surveyor on 7/14/15 at 3:10 PM that she updated the care plan the day prior and completed the pressure ulcer problem so that it was no longer active.</p> <p>Interview with E6 on 7/15/15 at 8:55 AM confirmed there was nothing in the care plan about toileting strategies or incontinence measures.</p> <p>On 7/15/15 at 12:30 PM E6 stated the resident's care plan was edited by adding incontinence care every 2 hours and as needed to the ADL Self Care Performance Deficit related to impaired balance problem. Nothing about interventions to promote continence or the use of barrier cream ordered by the physician.</p> <p>These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 and E2.</p> <p>5. R167 was admitted on 12/31/10 with multiple diagnoses including depression, anxiety (mental disorder with feeling of nervousness, fear or worrying) and dementia with delusions (belief held with strong conviction despite evidence to the contrary). The resident received an antidepressant daily.</p> <p>A care plan problem (initiated 7/9/12, last revised 6/17/15) entitled [Resident first name] is at risk for</p>	F 279		
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F 279 Continued From page 16
fall related injury as evidenced by: disease process/condition (dementia with delusions), impaired balance and mobility, medication usage (antipsychotic, antidepressant and antihypertensive). A care plan was not developed to address specific behaviors and interventions related the resident's depressive disorder.

On 7/15/15 at 8:50 AM E6 confirmed that a care plan addressing the resident's behaviors and interventions for depression was not created.

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These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 and E2.

F 280 SS= D 483.20(d)(3), 4831 O(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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

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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.

(F280)
A. Individual / Resident Impacted
R201 care plan for antidepressant use has been updated, and the pressure ulcer care plan was updated to reflect the issue was resolved.

B. Identification of other Residents
All residents care plans will be reviewed and updated to reflect the residents current care needs.

C. System Changes
The IDT will be re-inserviced on care plan revisions to reflect the residents current care needs.

D. Success Evaluation
The QA Director will conduct random audits of care plans on 10% of the overall census weekly until 100% is achieved consecutively for three weeks, and then audit monthly times two months. The QA Director will submit findings to the QAPI Committee meeting monthly.

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Continued From page 17

This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was determined that the facility failed to revise the care plan for 1 (R201) out of 42 sampled residents. Findings include:

The facility policy entitled Care Plans - Comprehensive (last revised 8/2006) included develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The resident's Comprehensive Care Plan is developed within seven days of the completion of the resident's comprehensive assessment (MOS). Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records.

R201 was admitted on 1/14/15 for rehabilitation after a fall at home. On admission the resident had an unstageable pressure ulcer due to the presence of slough and was taking medication for depression.

Review of R201's care plan (initiated 1/15/15, last revised 7/10/15) found problems entitled:
1) (resident first name] uses antidepressant medication [three specific medications listed] related to depression.
2) Resident has unstageable pressure ulcer related to impaired mobility and nutritional status.

F 280

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Continued From page 18
Physician order dated 4/10/15 by E4 (Physician) stopped one of the listed medications for depression.

On 5/13/15 E10 RN wrote on the Pressure Ulcer Evaluation form that R201's wound has healed.

An interview on 7/14/15 at 9:00 AM with E6 (Unit Manager) confirmed the pressure ulcer problem and the name of the discontinued antidepressant remained in R201's care plan. E6 removed the name of the discontinued medication at 9:10 AM.

On 7/15/15 at 3:10 PM E6 informed the surveyor the care plan had been edited the day before (removing the problem about the pressure ulcer).

On 7/17/15 at 8:10 AM review of the clinical record found the pressure ulcer problem had been removed from R201's current care plan.

The facility failed to revise R201's care plan timely to reflect the current treatment and status of the resident.

These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 NHA, and E2 DON

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F 309
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48325 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(F309)
A. Individual / Resident Impacted

F 309
The facility recognizes that no corrective action can be taken for R353 due to their discharge status.

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F 309	<p>Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R353) out of 42 sampled residents the facility failed to ensure pain medication was consistently evaluated after administration for effectiveness. Findings include: The facility's policy for Pain Assessment and Management (last revised 2010) documented that staff were to implement the medication regimen as ordered, carefully documenting the results of the interventions. The facility also utilized a PRN Pain Management Flow Sheet that directed the nurse to document the level of pain using a scale, the acceptable pain level, location of pain, behavioral scale, alternate treatment code, medication administered and the re-assessment of pain 30 minutes to one hour after administration. R353 had a physician's order dated 6/25/15 for Oxycodone (narcotic pain medication) every 6 hours as needed for moderate pain. The order was increased in frequency to every four hours on 7/7/15. The resident's care plan dated 7/8/15 for pain to bilateral knees documented as a goal (R353's name) will state/demonstrate relief or reduction in pain intensity to acceptable pain level as stated on MAR within 30 minutes to 1 hour after receiving interventions through the next review. Approaches included: -administer and monitor for effectiveness and for possible side effects from routine / prn pain meds</p>	F 309	<p>B. Identification of other Residents An audit will be completed by the unit managers or designee for all residents receiving pain medication to ensure pain medication is consistently evaluated after administration for effectiveness. The audit will include the PRN pain management flow sheet and the MAR (medication administration record).</p> <p>C. System Changes All licensed nursing staff will be re-in-serviced on the PRN pain management flow sheet to ensure pain medication is consistently evaluated after administration for effectiveness.</p> <p>D. Success Evaluation Daily audits will be conducted of the MARs to ensure pain medication is consistently evaluated after administration for effectiveness until 100% compliance is achieved for three consecutive times, and then weekly audits will be conducted times two months. Findings will be reviewed with the QAPI Committee meeting monthly.</p>	9/1/2015
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F 309 Continued From page 20
-monitor and report to nurse signs and symptoms or worsening of pain
-notify MD if pain relief interventions not effective.

F 309

Review of the MAR revealed that between 6/25/15 and 7/17/15 R353 was administered 43 doses of Oxycodone. Review of the PRN Pain Management Flow Sheet revealed that 19 of the 43 doses were not included on the Flow Sheet for assessment which included the post pain assessment.

Four (6/30, 7/12, 7/15 and 7/16/15) of the Oxycodone doses that were documented on the Flow Sheet failed to have a post-pain assessment.

An interview on 7/20/15 at 10:40 AM with ES, Unit Manager after reviewing the above findings provided no additional information on the lack of use of the Flow Sheet and lack of post-pain assessment.

These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315 (F315)

A. Individual / Resident Impacted
R201 Bladder assessment was completed. A three day voiding diary was initiated, completed and pattern established. Care plan for incontinence and toileting program was completed for R201. The facility recognizes no corrective action can be taken for R318 due to their discharge status.

G Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

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This REQUIREMENT is not met as evidenced by:
Based on record review, interview and review of facility policy, it was determined that the facility failed to ensure appropriate treatment and services to restore and/or maintain bladder function were implemented for 2 (R201 and R318) out of 42 sampled residents. The facility failed to assess bladder function for these residents after incontinence was identified and failed to provide interventions, treatment and services to assist in maintaining or improving as much urinary continence as possible for these residents. This resulted in R201, who was admitted with only occasional incontinence in January 2015, progressed to being frequently incontinent. R318 progressed from frequently incontinent in April, 2015 to being always incontinent in June, 2015. Findings include:

Facility policy (undated) entitled Urinary and Bowel Incontinence - Evaluation and Management included the following policy interpretation and implementation:

- * Nursing staff will initially screen for information related to urinary and bowel incontinence utilizing the Bowel and Bladder Evaluation.
- * Upon completion of the Bowel and Bladder Evaluation, should the history indicate anything other than continent, a three day, 24 hour, voiding and elimination diary will be implemented.
- " The diary will be initiated upon completion of the Bowel and Bladder Evaluation. The resident will be checked every hour for three days. The diary will be scored using a separate key, one for bowel and one for bladder.
- * Should the resident be asleep at any time, they

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B. Identification of other Residents
All residents will be evaluated. Residents who are assessed as appropriate will have a toileting program initiated and care plan in place.

C. System Change
Licensed nursing staff and new hires will be in-serviced on the bladder assessment policy and procedure. Policy and procedure will be reviewed and revised. Bladder function will be evaluated upon admission / re-admission, quarterly and with significant change in condition. Residents assessed as appropriate for a toileting program will have a care plan and toileting program implemented to maintain as much normal bladder function as possible. The nursing department will meet weekly for four weeks to assess the residents established toileting pattern, and to ensure residents have received appropriate interventions. MDS Coordinator will notify unit managers of any resident decline in bladder function through the MDS incontinence decline form.

D. Success Evaluation
The nursing administration / designee will conduct weekly audits of bladder function for newly admitted / re-admitted residents, residents due for a quarterly assessment and those with significant change in condition times four weeks then monthly for two months. A weekly audit will be completed by the QA Director / designee of the MDS Coordinator MDS incontinence decline form weekly times four weeks then monthly for two months. Findings will be reviewed with the QAPI committee monthly meeting.

9/1/2015

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NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966
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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 315	<p>Continued From page 22</p> <p>will not be awakened. However, should the resident require incontinence care during any time of the check, care will be provided immediately.</p> <ul style="list-style-type: none"> * Subsequent to the completion of the three day diary, an analysis of the data collected will be completed and trends will be reviewed to determine the appropriateness of a toileting program for bowel or bladder or both. * Upon evaluation of the data collection from the three day elimination diary, a decision will be made to determine the type of toileting program appropriate for the individual resident. * A plan of care developed specifically to meet the resident toileting needs. * Periodically (as required and when there is a change in pattern of elimination), staff will re-evaluate each individual's level of continence. <p>Cross Reference F279, example #4</p> <p>1. R201 was admitted 1/14/15 to the rehabilitation unit from the hospital after falling at home and developing acute renal (kidney) failure in the hospital. Besides multiple medical conditions, the resident had a history of bipolar disorder (mood disorder) and had been receiving medications for depression symptoms.</p> <p>Admission progress note on 1/14/15 at 8:10 PM by E12 (LPN) documented the resident was continent of urine. Bladder and Bowel Evaluation on 1/14/15 recorded a history of frequent incontinence and that the resident was unaware of bladder urges. Mobility devices included walker, raised seat and bed pan. Bladder summary showed incontinence (initiate voiding diary). The voiding diary from 1/15/15 through 1/17/15 showed R201 was continent of urine during this time frame. There were no</p>	F 315		
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F 315	<p>Continued From page 23</p> <p>documented episodes of incontinence and the resident was continent of bladder [used toilet] 4 to 5 times per day.</p> <p>MOS assessment dated 1/21/15 (5-day) and 1/28/15 (14-day) documented the resident was occasionally incontinent of urine and was not on a urinary training program. R201 required extensive assistance (staff provide weight-bearing support) with one person for bed mobility, transfer and toilet use. Resident balance when moving from seated to standing position and moving on/off the toilet was not steady, only able to stabilize with staff assistance. BIMS (Brief Interview for Mental Status, tool used to score mental ability) score was 15 out of 15 (15/15) showing the resident's cognition (thinking) was intact.</p> <p>A 1/22/15 progress note at 11:03 AM E5 (Unit Manager) documented analysis of the voiding diary as "continent of urine".</p> <p>Resident Bowel and Bladder by Shift report (based on CNA documentation) for the month of January, 2015 showed the resident had urinary incontinence 19.6% of shifts.</p> <p>Progress note on 2/4/15 at 9:14 AM by E4 (Physician) documented that the resident complained of increased depression.</p> <p>On 2/4/15 at 7:46 PM E13 (Director of Social Services) documented R201 did not want to go to therapy [physical and occupational therapy] and that the resident wanted more assistance [from staff] and was really down [depressed mood].</p> <p>Care plan (last revised 7/10/15, initiated 1/19/15)</p>	F 315		
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F 315	<p>Continued From page 24</p> <p>contained the problem entitled ADL Self Care Performance Deficit related to impaired balance with the goal of maintaining or improving the current level of function. Approaches included front wheel walker which resident was not to have walker in the room; Assist of 1 with transfers, resident noncompliant, education provided to resident related to safety and calling for assistance; Encourage resident to discuss feelings about self-care deficit; Encourage resident to participate to fullest extent possible with each interaction, encourage to use call bell for assistance. Care plan problem entitled Resident has unstageable pressure ulcer related to impaired mobility and nutritional status contained these approaches Provide incontinence care after incontinence episode; and Apply barrier cream as needed. Interventions about the resident's toileting or promoting continence were not documented in the care plan.</p> <p>MDS assessment (30-day) dated 2/11/15 documented the resident was frequently incontinent of urine, an increase of incontinence frequency.</p> <p>On 2/13/15 at 4:56 PM E4 (Physician) wrote since increasing an antidepressant medication, the "patient's mood seems to be better".</p> <p>On 2/22/15 at 4:11 PM E14 (RN) documented that R201 used the call bell today when needing assistance with ADLs.</p> <p>On 2/24/15 the resident moved to the Long Term Care unit.</p> <p>Resident Bowel and Bladder by Shift report for</p>	F 315		
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F 315	<p>Continued From page 25</p> <p>the month of February, 2015 showed the resident had urinary incontinence 31.3% of the shifts.</p> <p>Progress notes revealed dialysis (cleansing of blood by artificial means when kidneys have failed) started three times a week on 3/21/15 and R201 was hospitalized on 3/31/15 at a psychiatric facility for increase in depression with suicidal thoughts.</p> <p>Resident Bowel and Bladder by Shift report for the month of March, 2015 showed the resident had urinary incontinence 51.1 % of the shifts.</p> <p>Bladder and Bowel Evaluation dated 4/10/15 (date resident returned from psychiatric hospital) by E6 (Unit Manager) documented the resident had frequent incontinence and was not aware of bladder urges. Mobility devices included ambulatory, walker, raised toilet seat, bed pan, grab bars. Bladder summary was incontinent (initiate voiding diary). A voiding diary was not in the medical record.</p> <p>On 4/10/15 E9 (Physician) ordered to apply house barrier cream to perl-area (area between thighs and the anus) and buttocks after each incontinence episode and as needed.</p> <p>On 4/10/15 the resident's BIMS score remained 15/15 according to the clinical record.</p> <p>On 4/13/15 at 8:38 AM by E7 (Nurse Practitioner) documented R201 was still somewhat flat [affect], monotone in communication. Underlying issue seemed to be recently starting dialysis. The resident did not want to return to the psychiatric hospital.</p>
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Continued From page 26

F 315 MDS dated 4/17/15 (5-day) showed the resident was frequently incontinent of urine and not on a urinary training program. Amount of staff assistance and resident balance remained unchanged from January.

On 4/27/15 at 2:54 PM by E21 (LPN) documented the resident "continues to say she can't do something when in fact she can and wants the staff to do it all for her."

E7 documented on 4/28/15 at 10:49 AM that R201 "continually reports that she is unable to do things yet when left alone, she will stand and pivot to get in and out of bed on her own". The resident was alert but very monotonic [monotone voice] and seemed to have little motivation.

Resident Bowel and Bladder by Shift report for the month of April, 2015 showed the resident had urinary incontinence 65% of the shifts.

Resident Bowel and Bladder by Shift report for the month of May, 2015 showed the resident had urinary incontinence 85.7% of the shifts.

Resident Bowel and Bladder by Shift report for the month of June, 2015 showed the resident had urinary incontinence 100% of the shifts.

Bladder and Bowel Evaluation on 7/4/15 at 3:11 PM (quarterly) by E16 (LPN) documented the resident as always incontinent, a further decline from April. Mobility devices included ambulatory and grab bars. Bladder summary was incontinent (initiate voiding diary). A voiding diary was not in the resident's record.

On 7/14/15 at 3:10 PM E6 informed the surveyor

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Continued From page 27

F 315 she updated the care plan. Review of the resident's care plan found the pressure ulcer problem including the approach for providing incontinence care after an incontinence episode and to apply barrier cream had been discontinued/removed.

On 7/15/15 at 8:55 AM E6 confirmed there was nothing in the care plan about toileting strategies or incontinence measures. At 9:10 AM E6 verified the only three day diary in the chart was from January and stated she would check in medical records for voiding diaries conducted after the Bladder and Bowel Evaluations in April and July.

On 7/15/15 at 12:15 PM E6 informed the surveyor she edited the care plan again. Review of R201's care plan found the approach of performing incontinence care every 2 hours and as needed was added to the problem entitled AOL Self Care Performance Deficit related to impaired balance. Approaches addressing the resident's motivation issues, toileting strategies to promote continence or using barrier cream ordered by the physician were not included in the care plan.

Resident Bowel and Bladder by Shift report for the month of July, 2015 (through 7/16/15) showed the resident had urinary incontinence 91.7% of shifts.

On 7/20/15 at 8:15 AM E6 stated she usually would receive an email from the RNAC whenever the MOS assessment showed a decline in continence and would initiate the voiding diary and place the diary form in the CNA binder. E6 commented she reviewed her emails the day

F 315

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F 315	<p>Continued From page 28</p> <p>the decline in bladder function. E6 confirmed no three day diaries were done, and added they "should have been done". E6 added that she often had to talk with the resident when it was time to get out of bed since the resident often refused to get up for the aides. "When I go in, she stands right up".</p> <p>On 7/20/15 at 8:30 AM the surveyor talked with R201 about her continence status. R201 offered no reason for the decline in bladder function and denied feeling the urge to urinate prior to doing so. The resident admitted that it was easier to get cleaned up in bed versus getting up to go to the bathroom.</p> <p>At 8:45 AM E15 (QA Director) informed the surveyor she reviewed R201's record the day prior (Sunday) and talked with staff, who informed her the resident refused to get out of bed to use the bathroom but pressed the call bell after the resident was incontinent.</p> <p>Following a decline in urinary function identified during MDS assessments the facility failed to plan for, and provide, interventions, treatment and services to assist in maintaining or improving as much urinary continence as possible for this resident. This resulted in the resident who was admitted with only occasional incontinence progressing to being frequently incontinent.</p> <p>These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1 (NHA) and E2 (DON).</p> <p>2. The following information was found in R318's clinical record;</p>	F 315		
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F 315	<p>Continued From page 29</p> <p>3/26/15- R31S was admitted to the facility with multiple diagnoses, including epilepsy (seizure disorder), history of CVA (stroke), malnutrition, weakness, and dementia.</p> <p>4/1/15 through 4/3/15 a "Three day voiding diary" was begun. The diary was blank, indicating missed entries on: -4/1/15 from 3:00 PM through 10:00 PM -4/2/15 from 11:00 AM through 2:00 PM -4/3/15 from 3:00 PM through 10:00 PM.</p> <p>4/2/15 -An admission MDS Assessment indicated R31 S was frequently incontinent of bladder.</p> <p>5/21/15- An order was written for an antibiotic with the diagnosis of urinary tract infection.</p> <p>6/15/15- A quarterly MOS Assessment indicated R31S was always incontinent, a decline from the previous MOS assessment in April. There was no evidence that a voiding diary was done following this assessment.</p> <p>Review of R31S's clinical record revealed the facility did not develop a care plan to address the initial level of incontinence, assessed in April at the time of the admission MOS assessment nor following the quarterly MOS assessment in June.</p> <p>During an interview on 7/17/15 at 10:50 AM with ES unit manager it was confirmed that the voiding diary documentation was incomplete and that a new diary should have been done as well as a care plan to address R31S's incontinence.</p> <p>During an interview on 7/20/15 at 10:05 AM ES confirmed that there were no clinical interventions or responses initiated by the facility to address</p>	F 315		
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NAME OF PROVIDER OR SUPPLIER

085037

STREET ADDRESS, CITY STATE, ZIP CODE

ATLANTIC SHORES REHABILITATION & HEALTH CENTER

231 SOUTH WASHINGTON STREET
MILLSBORO, DE 19966

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F 315 Continued From page 30

R318's decline in continence as indicated by being assessed as frequently incontinent on admission in April, then declining to always incontinent in June. ES stated she was not notified of R318's decline in continence but did receive notification via e-mail on 6/18/15 from the RNAC that R318 had an overall clinical decline. An order for a hospice consult was written that day as well. ES confirmed that a hospice consult would not dismiss the facility from responding to a decline in R318's continence. Based on the resident's comprehensive assessment the facility failed to ensure that R318, once identified as incontinent of urine was provided appropriate treatment and services to achieve and maintain as much normal urinary function as possible. Following two comprehensive assessments the facility failed to provide evidence that R318 received interventions, treatment, and services to assist in maintain as much urinary continence as possible. These findings were reviewed on 7/20/15 at approximately 2:15 PM with E1, and E2.

F 315

F 323
SS=D

48325(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced

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F 323 Continued From page 31
by:
Based on observation during the environmental tour it was determined that the facility failed to maintain the environment free of accident hazards on one out of four resident units. Findings include:

Observation during the environmental tour of all four resident units on 7/15/15 from 10:30 AM - 11:15 AM and again from 2:15 PM - 2:45 PM the following was observed;

-In rooms 104, 118, 120 and 207 the toilets were loose posing a risk for residents when sitting on, or transferring from, the toilet.

- Outside of room 111 there were several deep indentations in the faux tile floor creating a potential tripping hazard.

These findings were reviewed with E17, Director of Maintenance on 7/17/15 at 11:30 AM.

(F323)
F 323
A. Individual / Resident Impacted
Resident room numbers 104, 118, 120, 207 toilets were fixed immediately. Hallway outside of rm# 111 floor was fixed so the floor indentation is leveled.
B. Identification of other Residents
All resident room toilets were checked by Maintenance dept and any loose toilets found were fixed. All hallway floors throughout facility were checked. Any repairs needed were completed timely.
C. System Changes
All staff have been in-serviced to report if a toilet is loose. All ambassadors were in-serviced to check the toilets being loose and floor indentation during their ambassador rounds and placed in REQQR to be addressed.
D. Success Evaluation
The Maintenance Director / designee will conduct weekly audits of REQQR requests and assure timely completion on maintenance related issues for one month then will audit monthly times two months. The Maintenance Director will reconcile REQQR requests with identified issues through ambassador rounds. Findings will be reviewed with the QAPI committee meeting monthly.

F 371 SS= E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

9/1/2015

This REQUIREMENT is not met as evidenced by:

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F 371	<p>Continued From page 32</p> <p>Based on observation and interview it was determined that the facility failed to store and serve food in sanitary conditions. Seven out of eight nourishment refrigerators had inaccurate temperatures log instructions. The refrigerator temperatures were not always maintained at or below 41 F. One out of eight refrigerators were unclean. Staff was also observed touching resident's [R62] food with bare hands. Findings include:</p> <ol style="list-style-type: none"> 1. During lunch observation on 7/8/15 at 1220 PM E11 CNA was observed setting up R62's tray and held a roll in her bare hand and filling it with chicken. E11 then handed the roll to R62 with her bare hand. A barrier, utensil or gloves should be used when handling food. 2. On 7/17/15 during the environmental tour between 9:30 AM and 10 AM it was noted the nourishment refrigerators in all four units had a temperature log that noted the acceptable temperature to be between 36 F and 46 F. The nourishment refrigerators need to be at or below 41 F. <p>Review of the logs revealed the following temperature readings above 41 F;</p> <p>Beach Cove - 7/3/15 42 F, 7/4/15 44 F 7/16/15 42 F and 7/17/15 42 F.</p> <p>Ocean Garden - 7/9/15 42 F, 7/11/15 44 F, and 7/14/15 42 F.</p> <p>Bay Terrece - 7/1/15 62 F, 7/3/15 48 F, 7/6/15 46 F, 7/13/15 48 F and 7/14/15 60 F.</p> <ol style="list-style-type: none"> 3. Observation on 7/17/15 at 9:30 AM of the 	F 371	<p>(F371)</p> <p>A. Individual / Resident Impacted</p> <ol style="list-style-type: none"> 1. The facility recognizes there is no corrective action for this deficient practice. There was no negative outcome to R62 as a result. E11 was in-serviced by staff development. 2. New temperature logs were placed on all nourishment refrigerators reflecting the appropriate temperatures not to be above 41 degrees. 3. Nourishment refrigerator on Beach Cove was cleaned and defrosted. <p>B. Identification of other residents</p> <ol style="list-style-type: none"> 1. All residents who require assistance with feeding have the potential to be affected by this deficient practice. Staff observation during meals time for proper food handling. 2. All residents requiring additional nourishment or meal supplements have the potential to be affected by this deficient practice. All temperature logs were checked by food services to assure temperatures were within acceptable range. 3. No other resident were identified to be affected by this deficient practice. <p>C. System Change</p> <ol style="list-style-type: none"> 1. Nursing staff will be in-serviced regarding sanitary food serving and handling. All new hires will be in-serviced at orientation. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID

PRINTED: 07/29/2015
FORM APPROVED
OMB NO 0938-0391

SYSTEM OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966
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F 371	Continued From page 33 nourishment refrigerator on Beach Cove was noted to be dirty with spilled liquids, the freezer section had 7 individual chocolate ice cream containers with frozen drips on the sides and tops, and the freezer was in need of defrosting. E6, unit manager was present and called housekeeping to clean the refrigerator. These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.	F 371	(F371 cont') 2. Nursing and dietary staff will be in-serviced regarding appropriate temperature ranges for the nourishment Refrigerators and these will be monitored daily. Temperatures noted out of range will be recorded and a maintenance request will be placed in REQQR. 3. Nursing and dietary staff will be in-serviced on cleaning schedule monthly and as needed. Policy and procedure will be reviewed and revised as needed.	
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F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC· 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	F 425	D. Success Evaluation 1. Weekly observation by nursing administration during meal times four weeks then monthly times two months and Findings will be reviewed with the QAPI committee meeting monthly. 2. Dietary manager will inspect all refrigerator temperature logs weekly times four weeks then monthly times two months, and findings will be reviewed with the QAPI committee meeting monthly. 3. Dietary manager will inspect nourishment refrigerators for cleanliness and need for defrosting weekly times two weeks then monthly times two months. Findings will be reviewed with the QAPI Committee meeting monthly.	9/1/2015
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID

PRINTED: 07/29/2015
FORM APPROVED
OMS NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING - B. WING -	(X3) DATE SURVEY COMPLETED 07/20/2015
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F 425	<p>Continued From page 34</p> <p>determined that the facility failed to ensure that accurate and complete accounting of narcotic medications [on 10 occasions] for one (R353) out of 42 sampled residents was completed. Findings include:</p> <p>The facility's policy for Medication Administration (last revised in 2007) documented that the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next one.</p> <p>R353 had a physician's order dated 6/25/15 for Oxycodone IR (narcotic pain medication) every six hours as needed for pain. On 7/17/15 this order was changed to every four hours.</p> <p>Review of R353's MAR and PRN Pain Management Flow sheet in comparison to the Controlled Drug Administration Record revealed that 10 doses were signed out on the Controlled Drug Administration Record but not signed as administered on the MAR and/or PRN Pain Management Flow sheet. The 10 doses missing documented administration involved 5 different nurses.</p> <p>Review of the Controlled Drug Administration Record also noted that on 7/15/15 at 5:30 PM a nurse documented signing out an Oxycodone, this was also signed out on the MAR. On 7/15/15 at 7:00 PM another nurse signed out a Oxycodone from the Controlled Drug Administration record and documented on the PRN Pain Management Flow sheet that it was administered. The 7:00 PM dose was not documented on the MAR. The Oxycodone was administered 1 1/2 hours apart instead of every</p>	<p>(F425)</p> <p>F 425</p>	<p>A. Individual / resident Impacted The facility recognizes there is no corrective action for R353 due to their discharge status.</p> <p>B. Identification of other Residents Nursing staff will review Narcotic declining sheet against the MAR and Pain flow sheet for accurate and complete accounting of narcotic medications.</p> <p>C. System Change Nursing staff and all new hires will be in-serviced on the policy and procedure on accurate and complete documentation of narcotic medications, and reconciliation of narcotic declining inventory sheet.</p> <p>D. Success Evaluation Nursing Administration will conduct a daily audit for two weeks of narcotic declining count sheet against the MAR and the Pain flow sheets to ensure compliance, then weekly audits for two months, and then monthly ongoing. A monthly report of this audit will be submitted by QA Director to the QAPI committee meeting monthly.</p>	<p>9/1/2015</p>
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Continued From page

F 425 35 four hours as ordered.

The facility's Medication Administration Policy and Controlled Substances Policy does not address reconciling the Controlled Drug Administration Record with actual Medication Administration Record.

An interview on 7/20/15 at 10:40 AM with E5 unit manager revealed that after reviewing the discrepancies, there was no further information about the 10 doses that were signed out on the Controlled Drug Administration Record but not documented as administered on the MAR.

These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the

F 425

F 431 (F431)

A. Individual / Resident Impacted
Expired medications Cephalexin Antibiotic medication which was not being used for resident was immediately removed from med cart. The albuterol inhalation medication was removed from the medication cart as it did not have the residents name on the box. There was no negative outcome.

B. Identification of other Residents
All other medication carts were inspected the same day and were found to be in compliance.

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F 431	<p>Continued From page 36</p> <p>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to ensure two out of nine medication carts were free of expired and/or unlabeled medications. Findings include:</p> <ol style="list-style-type: none"> 1. On 7/10/15 at 1:30 PM a medication cart was reviewed on the Beach Cove unit. An antibiotic (Cephalexin) was found to have expired on 6/30/15. Interview with E6 unit manager at the same time revealed that the resident was no longer taking this medication and she disposed of the medication. 2. On 7/10/15 at 1:40 PM a second medication cart was reviewed on the Beach Cove unit. There were 3 single unit doses of albuterol inhalation (for breathing treatments) in the cart. The vials were not labeled with the resident name or expiration date. Interview with E6 confirmed the observation and she disposed of the medication. 	F 431	<p>C. System Changes</p> <p>Nursing staff will be in-serviced on checking the medication carts daily for any expired medications and removing items.</p> <p>All new hires will be in-serviced on the policy and procedure on checking med carts daily for any expired meds. Policy and procedure for checking med carts and tx carts was reviewed and revised.</p> <p>D. Success Evaluation</p> <p>11-7 shift will check med carts and tx carts daily. Unit Managers will check Med carts and Tx carts weekly and report findings to the QA Director. A monthly audit will be done by nursing administration / pharmacy consultant and findings reviewed with the QAPI committee meeting monthly.</p>	9/1/2015
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CENTERS FOR MEDICARE & MEDICAID

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/20/2015
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F 431 Continued From page 37
These findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.

F 431

F 465 SS=E 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation it was determined that the facility failed to maintain a safe environment for staff in the kitchen area. Findings include:

1. On 7/9/15 at 9:40 AM water was noted on the floor near the stove where there was no non-skid mat in place. The water was coming from the leaking faucet of the pot filler. A return visit to the kitchen on 7/10/15 at 9:45 AM noted there to be water on the floor and a bucket was observed on the floor catching water drips.

The wet floor in the absence of non-skid surfaces posed a hazard to staff working in the kitchen.

Findings were reviewed with E1, NHA and E2, DON on 7/20/15 at 2:15 PM.

F 465

(F465)

A. Individual / resident Impacted
No resident / staff were affected by this deficient practice. The leaking faucet has been repaired, the bucket removed and the floor area dried.

B. Identification of other Residents
An audit of all leaking kitchen faucets was completed and repaired if indicated.

C. System Change
Kitchen staff will be educated on identifying kitchen maintenance and repairs. Staff will be instructed to enter any identified repairs into the REQQR system for maintenance follow up. Rubber matting has been employed in various risk locations throughout the kitchen flooring.

D. Success Evaluation
The Food Service Director or designee will audit for kitchen repairs and potential wet areas weekly times one month and monthly times two months. Findings will be reviewed with the QAPI Committee meeting monthly times three months.

9/1/2015



**DELAWARE HEALTH
AND SOCIAL SERVICES**

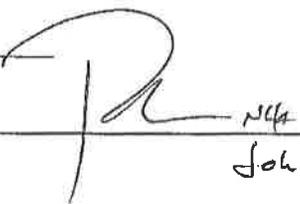
Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehabilitation and Health Center **DATE SURVEY COMPLETED:** July 20, 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 annual survey was conducted at this facility from July 9, 2015 through July 20, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 157. The stage two survey sample was forty two (42).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 20, 2015 F164, F242, F246, F253, F256, F279, F280, F309, F315, F323, F371, F425, F431, and F465.</p>	<p>The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 9/01/15.</p> <p>Cross refer to plan of correction CMS 2567-L survey completed 7/20/15 for Federal Tags F164, F242, F246, F253, F256, F279, F280, F309, F315, F323, F371, F425, F431, and F465</p>	<p>9/1/2015</p>

Provider's Signature  Title Administrator Date 8/7/15
John R. Bear