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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	08A020		08/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from August 11, 2015 through August 17, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 62. The Stage 2 survey sample size was 25. Abbreviations/definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; MD - Medical Director; FMD - Facility Maintenance Director; ADL - Activities of Daily Living/ADL/bathing, eating, toileting and hygiene; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Anti-Anxiety medication - used to treat any of several disorders that cause nervousness, fear, apprehension and worrying; Anticoagulant - medication that work to prevent the clotting of blood; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions;	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-7-15

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 Anxiety - an unpleasant state of inner turmoil, often accompanied by nervous behavior; BIMS - Brief Interview for Mental Status/tool used to measure mental abilities; Bladder schedule - a record of voiding (urinating) and leakage (incontinence) time of urine for 7 consecutive days; Blood sugar (BS) range - the normal fasting adult blood glucose range for an adult without diabetes is 74-106; BMP - Basic Metabolic Panel- set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; Carbohydrate controlled diet - people with diabetes find that eating a low-carbohydrate diabetes diet helps them to control blood sugar; CMP -Comprehensive Metabolic Panel- a group of blood tests that provide an overall picture of the body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy; Cognitive - thinking, memory functions; Continent - full control of bladder and/or bowel function; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dehydration - a condition in which the body has less than the normal amount of fluid; Diabetes - disease where blood sugar levels are high due to the body's insufficient production of the hormone, insulin; Diuretic - medicines that help reduce the amount of water/excess fluid in the body; Edema - retention of fluid into the tissue resulting in swelling; Fasting Lipid Profile - fasting/no food or fluids 12 hours prior to blood test; lipids are a group of fats and fat-like substances; results of the lipid profile	F 000		

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F 000	Continued From page 2 are used to determine effectiveness of lipid-lowering medications; Ferretin - a protein found inside cells that stores iron so your body can use it later; a Ferretin test indirectly measures the amount of iron in your blood; Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Functional Incontinence - when a resident is usually aware of the need to urinate but for a physical or mental reason he/she is unable to get to a bathroom; GERD - gastroesophageal reflux disease - occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe; GI doctor - a gastroenterologist is a doctor/physician who specializes in diseases of the digestive system; HbA1C - blood test that reveals how well one's diabetes is being controlled; Hypoglycemia - low blood sugar; Hyperglycemia - high blood sugar; Hyperlipidemia - too many lipids or fats in the blood; Incontinent/incontinence - loss of control of bladder and/or bowel function; Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own; Januvia - oral diabetes medicine that helps control blood sugar levels; Lantus Insulin - a long acting form of insulin used to treat diabetes; Locomotion - how resident moves between locations in his/her room and adjacent corridor on same floor, if in w/c, self-sufficiency once in chair;	F 000		

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F 000	Continued From page 3 MAR - Medication Administration Record; MDS - Minimum Data Set-standardized assessment form used in nursing homes; mg-Milligram- unit of mass or weight; MRR - Medication Regimen Review-a thorough evaluation of the medication regimen of a resident; review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team; NN - Nurse's Notes; Novolog Insulin - a rapid acting insulin used to lower blood sugar/glucose in treating diabetes; Occasionally incontinent - less than 7 episodes of incontinence during a 7 day look back period; Psychiatrist (psych doctor) - physician who specializes in the diagnosis and treatment of mental disorders; POS - Physician's Order Sheet; Prompted voiding - technique of bladder training in which the patient was instructed to urinate according to a predetermined schedule; pt - patient; Simvastatin - medication used to reduce blood lipid levels; Sliding scale with insulin coverage - a dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher; TAR - Treatment Administration Record; UTI- Urinary Tract Infection - bacteria in urine; w/c - wheelchair.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164		

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F 164	Continued From page 4 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone 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 observations and interview during Stage 1 and the environmental tour on 8/14/15 between 9:36 AM and 11:14 AM, it was determined that the facility failed to ensure the right to personal privacy for one (R24) out of 25 Stage 1 sampled residents. Findings include: The privacy curtain at the foot of the bed for R24 in room 307 was observed to not encompass the	F 164	1. Privacy curtain in rm 307 (R24) has been replaced with one appropriately sized to encompass the room portion to ensure resident privacy. 2. All resident rooms were checked to ensure that each resident's curtain provides sufficient privacy. 3. Monthly room audits will include checking for a complete encompassment of the room portion by the privacy curtain around each bed area. All monthly audits will be performed by Plant operations director or designee. See attachment #6. 4. The Plant Operations Manager or designee will audit 100% of resident rooms to ensure compliance. The Plant Operations Manager will examine 3 rooms per day until all rooms have been checked through the course of 14 days to ensure privacy curtains provide complete encompassment around each residents' bed area, then two times per week for two weeks and then three times per month until 100% compliance has been observed. The Plant Operations Manager will report findings through the QA process.	10/12/15

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F 164	Continued From page 5 entire bed area for privacy on 8/11/15 at approximately 10:10 AM during a Stage 1 observation and on 8/14/15 at 11:14 AM during the environmental tour. Finding was confirmed by E6 (FMD) on 8/14/15 on 11:14 AM.	F 164	F167 1.Survey Book moved to a document holder on the side of the desk in the lobby, making it accessible to people in a wheelchair. The location is labeled with thelarge typeface to aid those with visual impairment to identify the survey book easily. 2. Activities supervisor will inform residents at Resident Council meeting of the relocation and announce the placement of the survey book in the activities schedule handout, which is distributed to all residents on a weekly basis and is posted throughout the facility. See Attachment #9. 3. Survey Book will be stored in document holder affixed to the desk in the lobby. 4. Administrator will visually check weekly for proper placement of survey book until for 3 consecutive weeks to ensure it has remained in place. Administrator will report findings through the QA process.	10/12/15
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that the state inspection results were readily accessible to all residents. Findings include: The labeled binder containing the survey results was observed on 8/13/15 at 1:47 PM in a wall file holder mounted about 5 feet off the floor in the lobby. State inspection results were not readily accessible to residents in wheelchairs. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/15 at approximately 4:30 PM.	F 167		
F 170	483.10(i)(1) RIGHT TO PRIVACY -	F 170		

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F 170 SS=C	Continued From page 6 SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interviews, it was determined that mail was not promptly delivered to the residents on Saturdays. Findings include: During an interview on 8/14/15 at 1:45 PM, E10 (Business Office Manager) stated that mail was not delivered to the residents on Saturdays. E10 explained that Monday through Friday the mail was delivered to the business office, sorted, and personal mail was taken to the Activities Department for delivery to residents. On Saturdays, the business office was closed. No mail, business or personal, was delivered to the building on Saturdays. During an interview on 8/17/15 at 12:00 PM, E11 (CNA) confirmed that the Activities Department delivered personal mail to the residents Monday through Friday. E11 stated that although the Activities Department was staffed on Saturdays, no mail was delivered to residents as the business office was closed and no mail was delivered to the building. During a follow up interview on 8/17/15 at 12:18 PM, E10 confirmed that it was the facility's choice not to have mail delivered to the building on Saturdays. The usual postal worker was instructed not to come to the building on	F 170	F170 1. A mailbox has been installed in the lobby and Post Office has resumed Saturday delivery. 2. Post Office has been notified to resume Saturday delivery. Saturday mail delivery announced in the activities schedule handout, which is distributed to all residents on a weekly basis and is posted throughout the facility. See Attachment #9. 3. Activities Personnel working on Saturdays is responsible for retrieving the mail from the mailbox and delivering the mail to the residents. 4. Activities Supervisor will keep the announcement as a "sticky" in the weekly activities schedule for 3 months. Activities Supervisor will monitor the success of the Saturday delivery through weekly staff and resident interviews until Saturday delivery is reported 100% for 3 months. The Activities Supervisor will report findings through the QA process.	10/12/15

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F 170	Continued From page 7 Saturdays. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/15 at approximately 4:30 PM.	F 170	F246 1. R63's call bell was clipped to the bed to allow R63 to reach it. 2. DON and ADON inspected all beds to ensure call bells were in place for all residents. 3. Nursing staff in-serviced by Staff Development Nurse on 9/1/15 that call bell must remain clipped to bed at all times and must be reachable by the resident when resident is in bed. See attachment #5 for in-service details. 4. Nursing Staff in a supervisory role (DON, ADON, and Charge Nurses) will do semi-weekly audits to ensure call bells are placed properly for resident ease of access. See attachment #8. Supervisors will reinforce the requirement of call bell placement to staff if call bell found out of place. ADON or designee will review audits (attachment #8) on a monthly basis until 3 months of consecutive successful audits are performed to ensure residents are readily able to summon staff for their needs. ADON will report findings through the QA process.	10/12/15
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 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to have call lights in reach for one [R63] out of 25 residents that are capable of using them. Findings include: 1. On 8/11/15 at 11:08 AM, R63's call light was observed on the floor next to the bed in room 203. On 8/12/15 at 10:12 AM, R63's call light was on the floor next to the resident's bed. Findings were confirmed with E14 (CNA) on 8/12/15 at 10:23 AM and she immediately clipped the call light to the bed.	F 246		
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.	F 253		

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F 253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews during the environmental tour with E6 (FMD) on 8/14/15 between 9:36 AM and 11:14 AM, it was determined that the facility failed to have housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings include: The following observations were made during the environmental tour: 1. Room 103: - Entrance to bathroom and behind toilet had missing tile. - Stained ceiling tile above sink. 2. Room 110: - Air conditioning (A/C) unit was tethered to the wall using duct tape. - Wall area around A/C unit in disrepair. 3. Room 201: - Ceiling tile stained above B bed. - Walls with paint chipped and peeling. - Floor dirty. - Bathroom counter with sharp edge next to sink. - Wallpaper border peeling above B bed. - Closet doors scratched. - Scuff marks on wall around A and B beds. - Vent along wall next to B bed dirty. - Window A/C unit has holes. - A/C unit dirty. - Ceiling tile has hole in it by the bathroom. - Wall by bathroom scuffed and has holes/dents. - Ceiling tiles in the bathroom cracked and	F 253	RM 103 1. Ceiling tiles replaced. Bathroom floor replaced with new tiles. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 253	Continued From page 9 stained. - Mattress frame in A bed in disrepair. 4. Room 203: - Wall next to A bed in disrepair with scratches and peeling paint. - Ceiling tiles in bedroom and bathroom broken. - Sink counter chipped at bottom and has exposed holes and two holes patched, but not painted. - Bedroom door scratched at the bottom and chipped by doorframe. - Linoleum floor with tear and long scratch inside bedroom door. - Closet with piece of cover above door separating. 5. Room 205: - Wall heating unit has exposed wire mesh. - Dresser and sink area has exposed wood. - Peeling wall paper above B bed. 6. Room 208: - Bedroom wall has peeling paint and scratches. - Doorframe has chipped paint. - Bathroom door not closing properly. - A/C vent dirty. 7. Room 210: - Bedroom walls with peeling paint. - Dusty A/C vent. - Hole in ceiling tile in bathroom next to the light. - Screen window is broken. - Chipped paint in resident room. 8. Room 211: - Scuff marks on wall around A and B beds. - Hole in wall above hand sink. - Privacy curtain for B bed ripped at the top.	F 253	RM 110 1. Duct Tape removed and unit secured using screws. Wall has been repaired. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 253	Continued From page 10 - Stained tile above A bed. 9. Room 213: - Bathroom paint on back wall below vent was torn and peeling. - Over the toilet commode rusted. - Bathroom door jammed and unable to close all the way. 10. Room 214: - Scuff marks on wall around B bed. 11. Room 215: - Scuff marks on wall around beds A and B. - Bathroom paint in the back wall below the vent was torn and peeling. - Over the toilet commode rusted. - Crack on ceiling near the window. 12. Room 216: - Bedroom wall has scraped and peeling paint. - Scuff marks on the wall around A and B beds. - A/C unit had loose panel. 13. Room 217: - Protruding nails on wall adjacent to the backroom window. - Broken soap dispenser. - A/C unit board loose. 14. Room 221: - Anti-slip strips at back of room in disrepair. - Protruding nails on wall adjacent to the backroom window. - Ceiling tiles in disrepair. 15. Room 301: - Bedroom walls in disrepair. - Closet door not closing properly.	F 253	RM 201 1. Ceiling tiles replaced. Walls were patched and entire room repainted. The dirty floor was scrubbed clean. Sink moved to over sharp edge. Wallpaper border repaired. Scratched closet door sanded and stained. Scuff marks painted with entire room. Vent has been cleaned. Dirty window AC unit with holes has been replaced. Ceiling tiles in room and bathroom replaced as needed. Mattress frame has been replaced. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 253	Continued From page 11 - Left side of entry door frame gouged and chipped. - Space/hole around cable wire in ceiling tile to the left of the entry. - Over bed tray table for B bed in disrepair with peeling plastic. 16. Room 304: - Ceiling tiles over B bed stained. - Holes in ceiling tile around sprinkler head. 17. Room 306: - Scuff marks on wall around A and B beds. 18. Room 307: - Sink is slow draining. 19. Third Flood Dining Room: - Front door in disrepair. - Ceiling fan dusty. Findings were confirmed with E6 during the environmental tour. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/15 at 4:40 PM.	F 253	RM 203 1. Wall patched and painted. Ceiling tiles replaced as needed. Sink counter repaired and painted. Bedroom door sanded and stained. Floor tear sealed with epoxy. Closet door piece repaired. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15
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 observations made during the environmental tour on 8/14/15 between 9:36 AM and 11:14 AM, it was determined that the facility	F 256		

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	08A020		08/17/2015

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F 256	Continued From page 12 failed to provide adequate and comfortable lighting levels in all areas. Findings include: 1. The ceiling light in room 303 was observed not working properly. The light flickered when turned on. 2. Room 214 was observed to have inadequate lighting. Findings were confirmed by E6 (FMD) on 8/14/15 at approximately 11:14 AM.	F 256	RM 205 1. Exposed mesh removed. Exposed wood sanded and stained. Wallpaper repaired. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272		

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F 272	Continued From page 13 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to initially conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for three (R13, R47 and R67) out of 25 Stage 2 sampled residents. For R13, the facility failed to ensure the accuracy of the comprehensive admission MDS, dated 1/7/15, in the areas of medications and bowel and bladder continence. For R47, the facility failed to ensure the accuracy of the comprehensive MDS, dated 6/10/15, in the area of behaviors, specifically rejection of care. For R67, the facility failed to comprehensively assess her urinary incontinence and complete a 7 consecutive day bladder schedule since admission. Findings include: 1A. R13 was admitted to the facility on 12/29/14 with a diagnosis of Alzheimer's dementia and a history of blood clots in the legs and lungs. Review of the 12/29/14 physician's orders	F 272	RM 208 1. Walls and doorframe patched and/or painted as needed. Door closing repaired. A/C Vent cleaned. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 272	Continued From page 14 revealed R13 was on the anticoagulant medication, Xarelto from admission, but, not on any anti-anxiety medication. R13's admission MDS assessment, dated 1/7/15, was inaccurately coded that the resident received anti-anxiety medication during the last 7 days since admission to the facility and failed to code that R13 received an anticoagulant. In an interview, on 8/13/15 at 3:30 PM, E4 (RNAC) confirmed the findings. 1B. The admission nurse's note, dated 12/29/14 and timed 10 PM, stated R13 was incontinent of bowel and bladder. The "Activity of Daily Living Flow Record" stated R13 was incontinent of bowel and bladder from 12/29/15 through 1/7/15. The admission MDS assessment, dated 1/7/15, was inaccurately coded as "0" for R13's continence of bowel and bladder incorrectly, indicating that the resident was continent. In an interview, on 8/13/15 at 3:30 PM, E4 confirmed the findings. 2. Review of R47's nurse's notes, MAR, TAR, CNA ADL Flow Sheets, and Behavior Monitoring Sheets from 6/4/15 through 6/10/15 lacked evidence of any refusals of care. R47's annual MDS assessment, dated 6/10/15, stated under the "Rejection of Care - Presence & Frequency" question that behavior of this type occurred 4 to 6 days, but less than daily, during	F 272	RM 210 1. Walls patched and painted as needed. A/C vent cleaned. Ceiling tile replaced as needed. Window screen removed 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 272	Continued From page 15 the 7 day review period. The facility failed to accurately code the 6/10/15 annual MDS assessment. During an interview with E4 on 8/17/15 at approximately 1:58 PM, she confirmed the findings. Findings were reviewed with E2 (DON) on 8/17/15 at approximately 2:10 PM. 3. Cross refer to F315 R67 was admitted to the facility on 6/19/15 with diagnoses that included dementia. The nursing admission assessment, dated 6/19/15, stated that R67 was incontinent of urine and was unable to participate in bladder training due to dementia. The admission bladder assessment, dated 6/19/15, stated that R67 was not a candidate for retraining and may respond to a management program. The 6/19/15 physician's history and physical lacked evidence of R67's urinary incontinence. The admission MDS assessment, dated 7/1/15, stated that R67 was always incontinent of urine, required extensive assistance of 2 staff for toileting and was not on a toileting program. Despite the facility's bladder incontinence program which stated to complete the Bladder Incontinence Evaluation within 7 days of admission, the facility completed the bladder incontinence assessment on 7/4/15, a total of 15 days after admission. The 7/4/15 Bladder Incontinence Evaluation stated that R67 had functional urinary incontinence, was incontinent	F 272	RM 211 1. Paint touched up as needed. Hole has been fixed. Privacy curtain not ripped, but missing two hooks and has been repaired. Ceiling tile replaced. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 272	Continued From page 16 both day and night and treatment options included prompted voiding. The evaluation lacked evidence that the physician was notified or consulted regarding R67's urinary incontinence. R67's clinical record also lacked evidence of a 7 consecutive day bladder schedule to determine her pattern of voiding. In an interview on 8/17/15 at 11:36 AM, E4 stated that R67 had dementia and was not trainable. E4 stated that she reviewed the CNA documentation, nurse's notes, talked to staff and made observations of R67 herself to determine that R67 should be placed on a prompted voiding program as of 7/1/15. When E4 was shown a copy of the facility's Bladder Incontinence Program, dated 4/15/09, E4 stated that she thought it was an old policy. E4 confirmed that a 7 consecutive day bladder schedule was not done for R67. Findings were immediately confirmed with E4. In an interview on 8/17/15 at 1:57 PM, E3 (ADON) confirmed that the facility's 4/15/09 Bladder Incontinence Program was a current facility policy. The facility failed to comprehensively assess R67's urinary incontinence and they failed to complete a 7 consecutive day bladder schedule since her admission to the facility on 6/19/15.	F 272	RM 213 1. Bathroom patched and painted. Over the toilet commode replaced. Bathroom door repaired to close properly. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 17 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that 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. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to assure the accuracy of MDS assessments for four (R13, R18, R47 and R50) out of 25 Stage 2 sampled residents. Findings include: 1A. Review of the 4/15 physician orders revealed that R13 had the antipsychotic medication, Seroquel and the anticoagulant medication, Xarelto each ordered daily. Review of the 4/15 MAR revealed R13 received	F 278	RM 214 1. Walls patched and painted as needed. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 278	Continued From page 18 both Seroquel and Xarelto as ordered. R13's quarterly MDS, dated 4/7/15, section "N, Medications" was inaccurately coded as "0" for antipsychotic and anticoagulant medications incorrectly indicating that R13 did not receive them during the past 7 days. In an interview, on 8/13/15 at 3:30 PM, E4 (RNAC) confirmed the findings. 1B. Review of the 6/15 physician orders revealed R13 had the antipsychotic medication, Seroquel and the anticoagulant medication, Xarelto each ordered daily. Review of the 6/15 MAR revealed R13 received both Seroquel and Xarelto as ordered. Review of the 7/15 physician orders revealed R13 had the antipsychotic medication, Seroquel and the anticoagulant medication, Xarelto each ordered daily. Review of the 7/15 MAR revealed that R13 received both Seroquel and Xarelto as ordered. R13's quarterly MDS, dated 7/3/15, section "N, Medications" was inaccurately coded as "0" for antipsychotic and anticoagulant medications incorrectly indicating that R13 did not receive them the past 7 days. In an interview, on 8/13/15 at 3:30 PM, E4 confirmed the findings. 2. R50 began hospice services in January 2015. Review of R50's significant change MDS, dated	F 278	RM 215 1. Walls patched and painted as needed. Over the toilet commode replaced. Ceiling tile replaced as needed. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 278	Continued From page 19 2/17/15, revealed that he was coded as 4-2 (total dependence with one person physical assistance) for personal hygiene (includes how resident maintains hair combing, brushing teeth, shaving, washing/drying face and hands) and toilet use (how resident uses the toilet room/commode/bedpan/urinal). Review of R50's quarterly MDS, dated 5/7/15, revealed that he was coded as 1-1 (set up help with supervision) and 0-0 (no setup or physical help from staff). Review of R50's ADL Flow Records (completed by CNAs) for 5/1/15 through 5/7/15 (the 7 day look back period for the 5/7/15 quarterly MDS) revealed that R50 was totally dependent for personal hygiene or it did not occur and toilet use did not occur. During an interview with E4 on 8/17/15 at 9:28 AM, E4 confirmed that the 5/7/15 quarterly MDS was inaccurate for personal hygiene and toileting. She stated that R50 was dependent for all care except for setup help with eating. 3. Review of R47's nurse's notes, MAR, TAR, CNA ADL Flow Sheets, and Behavior Monitoring Sheets from 3/29/15 through 4/4/15 lacked evidence of any refusals of care. R47's quarterly MDS assessment, dated 4/4/15, stated under the "Rejection of Care - Presence & Frequency" question that behavior of this type occurred 1 to 3 days during the 7 day review period. The facility failed to accurately code the 4/4/15 quarterly MDS assessment. During an interview with E4 on 8/17/15 at	F 278	RM 216 1. Walls patched and painted as needed. A/C unit re-secured. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 278	Continued From page 20 approximately 1:58 PM, she confirmed the findings. Findings were reviewed with E2 (DON) on 8/17/15 at approximately 2:10 PM. 4. The quarterly Minimum Data Set (MDS) assessment, dated 3/5/15, stated R18 was receiving radiation while a resident in the facility under the Special Treatments, Procedures, and Programs section. The same MDS failed to list Cancer (disease characterized by rapid growth of cells in the body) as an active diagnosis. On 8/13/15 at 12:30 PM, E4 confirmed she should have included the diagnosis of Cancer on R18's quarterly MDS dated 3/5/15. The facility failed to accurately reflect R18's status in her quarterly MDS to include Cancer, for which she was receiving treatment at the time of the MDS.	F 278	RM 217 1. Vacant picture hanging nails removed. Soap dispenser repaired. A/C unit screws tightened. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director.	10/12/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and	F 309	4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	

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F 309	Continued From page 21 psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (R18 and R19) out of 25 Staged 2 sampled residents. Findings include: 1. Review of the clinical record revealed a GI consultation, dated 7/15/15, that stated to have R18's Omeprazole (medication used to treat GERD and other conditions caused by excess stomach acid) increased to 40 mg twice daily - 30 minutes before breakfast and dinner. Review of Physician's Telephone Orders, dated 8/13/15, also stated to have R18's Omeprazole increased to 40 mg PO (by mouth) twice a day (per GI recommendations). Review of the August 2015 MAR revealed that R18's Omeprazole dosage was incorrectly transcribed to "20 mg PO twice a day (per GI recommendations)". As a result R18 received the wrong medication dosage on two occasions: 8/13/15 at 4 PM and on 8/14/15 at 7 AM. During an interview with E5 (UM) on 8/14/15 at 10:43 AM, E5 confirmed that the Omeprazole order was transcribed incorrectly. E5 also stated that the facility has a 24 hour chart check system in place and the error should have been picked up then. During an interview with E12 (LPN) on 8/14/15 at 10:49 AM with E5 present, E12 stated she thought the 4 was a 2 when she transcribed the order. E12 stated that she initially wrote 40 mg, crossed it out, then wrote 20 mg PO twice a day instead. E12 also confirmed she made a medication error when she administered 20 mg of Omeprazole to R18 that morning. E12 also	F 309	RM 221 1. Anti-slip strips removed. Protruding nails removed. Ceiling tiles replaced. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 309	Continued From page 22 confirmed that she did not seek clarification of the physician's order from her Unit Manager, E5 or anyone else. Findings were reviewed with E3 (ADON) on 8/14/15 at approximately 10:55 AM. 2. Review of the August 2015 monthly POS revealed an order for R19 to have a CMP and Ferretin drawn every 6 months. Review of R19's clinical record lacked evidence that a CMP and Ferretin were drawn at any time in the past year. The last CMP found was from 2/11/14 and there were no Ferretin results. The facility failed to follow physician's orders when there was no CMP or Ferretin drawn as ordered. During an interview with E5 (UM) on 8/17/15 at approximately 9:00 AM, E5 confirmed that the blood work was not obtained as ordered. Findings were confirmed by E2 (DON) during interview on 8/17/15 at approximately 2:10 PM.	F 309	RM 301 1. Walls patched and painted. Closet door repaired to close properly. Door frame gouges sanded smooth and painted. Ceiling tile replaced around cable wire. Over bed table replaced. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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NAME OF PROVIDER OR SUPPLIER NEWARK MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 254 WEST MAIN STREET NEWARK, DE 19711	

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F 315	Continued From page 23 function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, review of facility's bladder incontinence program and review of other documentation, it was determined that for one (R67) out of 25 Stage 2 sampled residents, the facility failed to ensure that R67, who was incontinent of bladder, received appropriate treatment and services to restore as much normal bladder function as possible. Findings include: According to the American Medical Directors Association's (AMDA/The Society for Post-Acute and Long-Term Care (LTC) Medicine) Clinical Practice Guideline for Urinary Incontinence stated, "... Urinary incontinence should be managed, can often be modified, and sometimes be significantly improved or eliminated in frail older adults, including people with dementia who reside in LTC facilities. Use of the systematic approach ... should help caregivers and practitioners optimize the management of urinary incontinence in the LTC setting ... A bladder record or voiding diary may help to characterize the patient's incontinence ... Outcomes that may be expected from the implementation ... include ... Better identification of individuals who have a reversible urinary incontinence problem. More individualized approaches to urinary incontinence management ... Reduction in the number of significant complications of urinary incontinence ...". Refer to: http://www.amda.com/tools/guidelines.cfm. The facility's Bowel and Bladder Incontinence	F 315	RM 304 1. Ceiling tiles replaced as needed. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 315	Continued From page 24 Program, dated 4/15/09, stated the following goals: "... 1. To identify at-risk individuals who need intervention and the specific factors that put them at risk. 2. To maintain and/or improve ... bladder continence ... 6. To restore and maintain an optimum level of functioning as appropriate". The program stated, "1. When the resident is admitted to the facility the Admission Nursing Assessment is to be completed by nursing staff within 24 hours ... If resident is incontinent ... Within 7 days of admission the nursing staff will complete the ... Bladder Incontinence Evaluation to assist with the evaluation of the resident's continence status ... The resident will also be evaluated for ... bladder incontinence pattern by staff completion of the ... Bladder Schedule for 7 consecutive days ... The Bowel and Bladder Team (BBT) will complete the Evaluation for ... Bladder Training based on the data collected from the a) Admission Nursing Assessment, b) ... Bladder Incontinence Evaluation, c) ... Bladder Schedule, d) History and Physical, e) Physician Orders (especially noting medications), f) MDS ... If appropriate, attempts should be made to correct the cause(s) of urinary incontinence if treatable that have been determined by the BBT ... The BBT will complete the BBT Review of Incontinence Status ... The BBT documentation should include pertinent information that assisted the team to determine their plan of care, the planned toileting schedule, resident instructions that may be needed, expected results, a care plan and an attachment placed on the CNA ADL flow sheet ... The BBT must communicate all pertinent information to all staff including the type of program selected, specific approaches ... The nursing staff will also communicate any concern about the selected plan to the BBT so that the resident's continence status can be re-evaluated	F 315	RM 306 1. Walls patched and painted as needed. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 315	Continued From page 25 ...". R67 was admitted to the facility on 6/19/15 with diagnoses that included dementia. The nursing admission assessment, dated 6/19/15, stated that R67 was incontinent of urine and was unable to participate in bladder training due to dementia. The admission bladder assessment, dated 6/19/15, stated that R67 was not a candidate for retraining and may respond to a management program. Upon admission, R67 was care planned for alteration in skin integrity with approaches that included to keep her clean and dry and check her for incontinence every 2 hours. The 6/19/15 physician's history and physical lacked evidence of R67's urinary incontinence. Review of the CNA ADL Flow Record from 6/19/15 through 6/30/15 revealed that R67 was incontinent of urine every shift (100%). The admission MDS assessment, dated 7/1/15, stated that R67 was always incontinent of urine, required extensive assistance of 2 staff for toileting and was not on a toileting program. Despite the facility's bladder incontinence program which stated to complete the Bladder Incontinence Evaluation within 7 days of admission, the facility completed the bladder incontinence assessment on 7/4/15, a total of 15 days after admission. The 7/4/15 Bladder Incontinence Evaluation stated that R67 had	F 315	RM 307 1. Sink drain cleared and drains properly. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 315	Continued From page 26 functional urinary incontinence, was incontinent both day and night and treatment options included prompted voiding. The evaluation lacked evidence that the physician was notified or consulted regarding R67's urinary incontinence. R67's clinical record also lacked evidence of a 7 consecutive day bladder schedule to determine her pattern of voiding. On 7/6/15, R67 was care planned for potential for complications related to urinary incontinence. Approaches included the following: assess incontinence to determine if there is a pattern. assess for potentially reversible causes, cognitive function, motivation; check at least every 2 hours for incontinence ...; offer/assist to bed side commode at scheduled intervals during the day: before and after meals and PRN .... The CNA's Resident Status Sheet for R67 for July 2015 stated under the bladder section that R67 had self control of her bladder despite documented evidence of her urinary incontinence. Review of R67's clinical record revealed a July 2015 prompted toileting schedule, which listed 1st void, 2nd void and 3rd void on both day and evening shifts and 1st round (if awake) and last round on night shift. The July 2015 toileting schedule revealed that R67 was: - incontinent of urine on 153 out of 245 opportunities (62%); - dry on 61 out of 245 opportunities (25%); and - voided using the toilet with staff assistance on 31 out of 245 opportunities (13%). It was unclear in the clinical record how the facility individualized R67's prompted toileting schedule to meet her needs as the facility failed to complete a 7	F 315	3rd Floor Dining Room 1. Ceiling fan dusted and cleaned. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #14 details the routine maintenance and housekeeping tasks for all resident areas and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed resident area audit (attachment #14) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident area is addressed for all areas. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 315	Continued From page 27 consecutive day bladder schedule to determine her pattern of voiding since admission. Review of the August 1 - 16, 2015 toileting schedule revealed that R67 was: - incontinent of urine for 82 out of 125 opportunities (66%); - dry for 22 out of 125 opportunities (18%); and - voided using the toilet with staff assistance for 21 out of 125 opportunities (17%). In an interview on 8/13/15 at 2:32 PM, E16 (CNA) stated that R67 was incontinent of urine and on a check and change toileting program every 2 hours. E16 also stated that R67 "use to tell them (CNA's) when she needed to toilet but not so much anymore". In an interview on 8/17/15 at 8:05 AM, E17 (CNA) stated that R67 was both continent and incontinent of urine. E17 stated that R67 was not on a toileting program but sometimes she would need to be toileted when she would stand up from her wheelchair. In an interview on 8/17/15 at 11:36 AM, E4 (RNAC) stated that R67 had dementia and was not trainable. It was during this interview that E4 provided the 6/19/15 Admission Bladder Assessment and the 7/4/15 Bladder Incontinence Evaluation as those assessments were not located in R67's clinical record. E4 stated that she reviewed the CNA documentation, nurse's notes, talked to staff and made observations of R67 herself to determine that R67 should be placed on a prompted voiding program as of 7/1/15. When E4 was shown a copy of the facility's Bladder Incontinence Program, dated 4/15/09, E4 stated that she thought it was an old policy. E4	F 315	F256 RM 214 1. Defective ceiling lights in rm 214 replaced and work properly. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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F 315	Continued From page 28 confirmed that a 7 consecutive day bladder schedule was not done for R67. E4 also confirmed the CNA Resident Status Sheet was incorrect when it stated that R67 had self control of her bladder and R67's care plan for urinary incontinence was incorrect when it stated to check R67 every 2 hours for incontinence. In an interview on 8/17/15 at 1:57 PM, E3 (ADON) confirmed that the facility's 4/15/09 Bladder Incontinence Program was a current facility policy. The facility failed to ensure that R67, who was incontinent of bladder, received appropriate treatment and services to restore as much normal bladder function as possible.	F 315	RM 303 1. Defective ceiling lights in rm 303 replaced and work properly. 2. All resident areas have been inspected for any maintenance and housekeeping concerns for a sanitary, orderly, and comfortable interior and the findings have been addressed. 3. Attachment #6 details the routine maintenance and housekeeping tasks for all resident rooms and has space for unique issues for repairs. Audit will be completed by Environmental Services director. 4. This detailed room audits (attachment #6) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident room is addressed for all rooms. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R18) out of 25 Stage 2 sampled residents who display mental or psychosocial adjustment difficulty receive appropriate treatment and services to correct the problem. Findings include: R18 was admitted to the facility with diagnoses that included anxiety.	F 319		

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F 319	Continued From page 29 Review of the Nurse's Notes revealed the following: - 1st note dated 6/30/15 at 7 PM stated that E15 (MD) ordered a psychiatric consult. - 2nd note dated 6/30/15 at 8 PM stated that a new doctor's order was received for a psychiatric consult. -3rd note dated 6/30/15 at 8:15 PM stated that a page was sent to the psychiatrist and they were awaiting a call back. A physician's order, dated 6/30/15, stated "psych consult - (psychiatrist name) aware." Review of the clinical record during the survey between 8/11/15 through to 8/14/15 lacked evidence that a psych consult was ever done. The facility failed to ensure that R18 who displays mental or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem when a psychiatric consult dated 6/30/15 was never done. On 8/14/15 at 8:36 AM E3 (ADON) confirmed the findings.	F 319	F272 1A (R13) 1. MDS was reviewed and modified for R13 with medication coded correctly. Modified MDS were transmitted and accepted by CMS. 2. All other MDS for last quarter charts were reviewed by MDS Coordinator for errors in medication coding. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee. F272 1B (R13) 1. MDS was reviewed and modified for R13 with continence status coded correctly. Modified MDS were transmitted and accepted by CMS. 2. All other incontinent residents were checked for improper continence coding by MDS Coordinator. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1. New policy initiated for bladder continence care which pertains to all residents. See attachment #11. Nursing Staff in-serviced on 9/7/15 by Staff Development Nurse on new bladder policy. See attachment #10. 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee.	10/12/15 10/12/15
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323		

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			F272 R47	
F 323	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and review of other facility documents, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents for three (R19, R67 and R44) out of 25 Stage 2 sampled residents. For R19, the facility failed to apply w/c leg rests when transporting the resident according to the plan of care. For R67, the facility failed to ensure that R67's wheelchair alarm was applied and functioning at all times according to the plan of care. For R44 the facility failed to safely utilize extension cords and electric cords. Findings include: 1. R19 had diagnoses that included dementia with behaviors. According to the quarterly MDS assessment, dated 6/2/15, R19's daily decision making skills were severely impaired and she required extensive assistance of facility staff for locomotion on the unit. Review of a facility incident report, dated 7/12/15, revealed that R19 was restless and agitated and she was toileted by two (2) CNAs in an attempt to reduce her agitation. After toileting, R19 remained agitated and as she was being wheeled out of the bathroom while seated in a w/c, she suddenly placed her feet down (no leg rests in place) and fell forward hitting the left side of her face. R19 developed bruising and swelling of the left eye. In response to this fall, a new intervention was added to R19's care plan on 7/14/15, for the	F 323	1. MDS was reviewed and modified for R47 with rejection of care frequency coded correctly. All modified MDS were transmitted and accepted by CMS. 2. All other MDS were reviewed for errors in the coding for rejections of care by MDS Coordinator. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee F272 R67 1. Incontinence evaluation conducted by MDS Coordinator. MDS was reviewed and modified for R47. All modified MDS were transmitted and accepted by CMS. 2. All other residents were checked for missing or untimely incontinence evaluations by MDS Coordinator. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1New policy initiated for bladder continence care which pertains to all residents. See attachment #11. Nursing Staff in-serviced on 9/7/15 by Staff Development Nurse on new bladder policy. See attachment #10. 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee	10/12/15 10/12/15

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F 323	Continued From page 31 problem of high risk for falls that stated, "Must have leg rest (sic) on w/c when transporting, keep one hand on pt during transport." Review of the facility's investigation of the fall revealed that R19 was impulsive and unpredictable. The following observations were made of R19: - 8/12/15 at 10:50 AM - seated in a w/c with no leg rests being wheeled on 2nd floor to attend Mass; - 8/13/15 at 8:45 AM - being wheeled in a w/c with no leg rests into the 3rd floor lounge area and transferred to a recliner; - 8/13/15 at 11:40 AM - E8 (CNA) and E13 (CNA) transferred resident from recliner to a w/c with no leg rests and wheeled her into the bathroom; at 12:00 PM, E8 wheeled R19 out of the bathroom and while keeping one hand on her left shoulder wheeled her into the dining room; - 8/14/15 at 12:07 PM - E7 (RN) wheeled R19 into the dining room in a w/c with no leg rests. The facility failed to ensure assistance devices, leg rests, were utilized for R19 to prevent accidents. Findings were reviewed with E2 (DON) on 8/17/15 at approximately 2:10 PM. 2. The facility's policy "for assuring that resident alarms and safety devices are functioning and in place while in use", dated 7/1/13, stated, "all resident alarms will be monitored every shift and as needed to assure that they are in place and functioning correctly ...". R67 was admitted to the facility on 6/19/15. A physician's order, dated 6/19/15, stated that	F 323	F278 1A R13 1. MDS was reviewed and modified for R13 with medication coded correctly. Modified MDS were transmitted and accepted by CMS. 2. All other resident charts were reviewed by MDS Coordinator for errors in medication coding. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee. F278 1B R13 1. MDS was reviewed and modified for R13 with medication coded correctly. Modified MDS were transmitted and accepted by CMS. 2. All other resident charts were reviewed by MDS Coordinator for errors in medication coding. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee.	10/12/15 10/12/15

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F 323	Continued From page 32 R67 was to have bed/chair alarms at all times. A continuous observation on 8/11/15 from 1:12 PM to 1:19 PM revealed R67 standing up from her wheelchair six times without a functioning chair alarm. An observation on 8/12/15 at 1:20 PM revealed R67 sitting in her wheelchair in the 2nd floor dining room without a chair alarm. R67 was taken into her room to be toileted at 1:33 PM and returned to the 2nd floor dining room at 1:44 PM and was observed standing up multiple times from her wheelchair without a functioning chair alarm. An observation on 8/12/15 at 4:15 PM revealed R67 standing up multiple times from her wheelchair in the 2nd floor dining room with a chair alarm attached but not functioning. An observation on 8/13/15 at 9:57 AM revealed R67 standing up from her wheelchair in the 2nd floor dining room without a functioning chair alarm. In an interview on 8/13/15 at 2:32 PM, E16 (CNA) stated that R67 required a chair alarm at all times. Findings were reviewed with E3 (ADON) on 8/17/15 at 1:57 PM. The facility failed to ensure that R67's wheelchair alarm was applied and functioning at all times to ensure safety and prevent accidents. 3a. During the environmental tour on 8/14/15 at	F 323	F278 R50 1. MDS was reviewed and modified for R50 with ADLs coded correctly. Modified MDS were transmitted and accepted by CMS. 2. All other resident charts were reviewed by MDS Coordinator for errors in ADL coding. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee. F278 R47 1. MDS was reviewed and modified for R47 with rejection of care frequency coded correctly. All modified MDS were transmitted and accepted by CMS. 2. All other MDS were reviewed for errors in the coding for rejections of care by MDS Coordinator. None found. 3. MDS coordinator has received additional training on coding and assessment accuracy. See attachment #1 4. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Finding of errors will be reported to Quality Assurance Committee	10/12/15 10/12/15

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F 323	Continued From page 33 10:30 AM, an orange extension cord was observed hanging from the ceiling of R44's room and plugged into an outlet in the wall outside of the bathroom. 3b. A TV cable cord was observed hanging across the adjacent small table in R44's room on 8/14/15 at 10:31 AM. Findings were confirmed by E6 (FMD) on 8/14/15 at approximately 10:31 AM.	F 323	F309 1. MD was notified of incorrect dosage of Omeprazole was given to R18 on two occasions. 8/13/15 at 1600 and 8/14/15 at 0700. Order correctly transcribed to read "40mg P.O. bid, 30 minutes prior to breakfast and dinner". Resident was observed for any adverse reaction from wrong dose being given. No adverse reactions noted. 2. E12 and night nurse who did 24hr chart check were disciplined and instructed on the importance of accuracy of transcribing medication orders and 24 hr chart checks. See attachment #2	10/12/15
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	3. New policies for 24 hr chart check and transcribing medication were introduced. LPN and RN staff were in-serviced on the new policies. 4. Semi-weekly audits of all new medication orders and chart checks will be done for 3 months to ensure accuracy. Any variances will be reported to the Quality Assurance Committee. F315 1. An admission bladder assessment was done for R67, a 3-day diary was completed and resident was placed on prompted voiding program. 2. A 3-day diary will be completed on each resident and a bladder assessment will be completed after completion of diary. 3. A new bladder continence policy implemented. - A nurse will complete a continence assessment on admission, quarterly and after any significant change in condition. A 3-day voiding diary will be initiated to establish the resident's individual voiding pattern. See attachments #10 and #11 4. Random audits of bladder assessment and 3-day diaries will be done weekly by the social worker or designee. Any variances will be reported to the quality assurance committee.	10/12/15

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F 329	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs related to monitoring for two (R13 and R19) out of 25 Stage 2 sampled residents. Findings include: 1. R13 was on the diuretic medication, Lasix, due to high blood pressure and edema since admission on 12/29/14. R13 had a care plan entitled, "Dehydration R/T (related to) use of diuretics", developed on 1/5/15 and last revised on 8/9/15, with the goal that the resident would not become dehydrated. Approaches included to "monitor labs". Review of physician's orders from 1/15 through 8/15 revealed R13 had an order for a BMP laboratory test every 6 months in November and May as part of medication monitoring. R13's clinical record was reviewed and there was no evidence that R13 had a BMP laboratory test done in May 2015. In an interview, on 8/13/15 at 4:11 PM, E5 (UM) stated that no BMP lab was drawn for R13 in May, confirming the findings. During an interview, on 8/14/15 at 10:24 AM, E3 (ADON) also confirmed the findings. 2. The clinical record revealed R19 was receiving the medications Simvastatin daily for	F 329	F319 1. Psychiatric consult completed 8/18/15 and placed in R18's chart. 2. All residents' charts were checked to ensure no orders for medical consult were omitted. See attachment # 2 3. When the MD orders a consult, the nurse transcribing the order will notify the Social Worker of new consult. See attachment #12. The nurse will notify the consultant and write a nurse note. The social worker will follow up within 72 hours to ensure consult was done. The nurse will send social worker a copy of completed consultation. New policy initiated. Nurses were in-serviced by Staff Development Nurse on 9/7/15. 4. Semi-weekly chart checks will be completed by DON or designee for 3 months to ensure consults & assessments are completed. Any variances will be reported to quality assurance committee. F323 R19 1. Leg rest installed on R19's wheelchair. R19 has leg rest on wheel chair anytime R19 is in the wheelchair. 2. All residents that use a wheelchair were evaluated by ADON or designee to determine if leg rest would be needed for safety. 3. Any resident determined to need leg rests will be provided with leg rests. Staff inserviced by Staff Development nurse on 9/1/15 how to determine if a resident needs leg rests. See attachment #4 4. Semi-weekly audits will be done until 3 months of consecutive successful evaluations are completed by ADON or designee and any variance will be reported to the Quality Assurance Committee.	10/12/15 10/12/15

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F 329	Continued From page 35 hyperlipidemia and Januvia daily for diabetes. The August 2015 monthly POS included an order for a fasting lipid profile and a HbA1C to be drawn every six (6) months. Review of the clinical record lacked evidence that R19 had a fasting lipid profile or a HbA1C drawn in the past year and a half. The last HbA1C was drawn on 2/11/14 and the last fasting lipid profile was drawn on 1/17/14. The facility failed to ensure that R19 was free from unnecessary drugs and they failed to adequately monitor the effectiveness of the Simvastatin and Januvia. During an interview with E5 on 8/17/15 at approximately 9:00 AM, E5 confirmed that the blood work was not obtained as ordered. Findings were confirmed by E2 (DON) during an interview on 8/17/15 at approximately 2:10 PM.	F 329	F323 R67 1. R67 was provided with a tab alarm and chair alarm. 2. All residents with alarms were checked for placement and function. All residents charts were checked for physician orders for alarms. None found. 3. Any resident determined to need alarms will be provided with alarms. 4. Semi-weekly chart checks will be done until 3 months of consecutive successful evaluations are completed by ADON or designee and any variance will be reported to the Quality Assurance Committee.	10/12/15
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that residents were free of any significant medication errors for one (R26) out of 25 Stage 2 sampled residents. The facility failed to administer a long acting insulin, Lantus, twice and failed to	F 333	F323 3A R44 1. Extension cord removed. 2. All resident areas checked for hazardous extension cords. None found. 3. All loose wiring must be kept in a non-hazardous manner. 4. Weekly maintenance audits will check for hazardous wiring/cabling. Every room will be checked on a weekly basis until 3 months consecutive months of hazard-free wiring is achieved. Audit will be completed by Environmental Services director. Variances will be reported to QA Committee.	10/12/15

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F 333	Continued From page 36 administer the correct doses of a short acting insulin, Novolog, nine times. Findings include: 1A. R26 had a diagnosis of Diabetes and received insulin. R26's care plan entitled, "Potential for hyper/hypoglycemia, other complications related to Diabetes ..." initiated 9/28/12, and last revised 5/31/15, had the goals to remain free of signs/symptoms or complications related to Diabetes through the review date and to maintain blood sugars within acceptable range. Approaches included: "Assess/record/report to MD (medical doctor) prn (as needed): Hypoglycemia s/sx (signs/symptoms)... Hyperglycemia s/sx... ; Administer medications as ordered and monitor for side effects, effectiveness...". On 4/20/15 R26's physician ordered, "Do not call MD for BS (blood sugar) > (greater than) 300, notify MD in book; Okay to given med pass (nutritional supplement); ^ (Increase) Lantus (insulin) to 25 units q am (every morning)." On 4/28/15, the physician ordered R26's Lantus insulin to be decreased from 25 units to 20 units by injection every morning. Review of the 4/15 MAR revealed that Lantus 20 units by injection every morning on 4/29/15 and 4/30/15 was blank with no evidence that it was administered. Blood sugars (BS) on 4/29/15 were 177 at 7:30 AM, 260 at 11:30 AM, 54 at 4:30 PM and on 4/30/15 were 213 at 7:30 AM, 98 at 11:30 AM and 56 at 4:30 PM. NNs from 4/29/15 through 4/30/15 were reviewed	F 333	F323 3B R44 1. AV cable secured to the wall. 2. All resident areas checked for hazardous extension cords. None found. 3. All loose wiring must be kept in a non-hazardous manner. 4. Weekly maintenance audits will check for hazardous wiring/cabling. Every room will be checked on a weekly basis until 3 months consecutive months of hazard-free wiring is achieved. Audit will be completed by Environmental Services director. Variances will be reported to QA Committee. F329 R13 1. A BMP was obtained on 8/24/15 for R13. The results were within the normal limits. 2. All residents charts were checked to ensure routine labs were completed per Medical Director's orders. 3. Consultant pharmacist was made aware and educated on the need to conduct a thorough investigation of routine labs and notify DON of any routine labs that have not been completed. New policy on routine labs initiated, RNs and LPNs were educated. See attachment #3 Labs will be monitored weekly by designee. 4. Semi-weekly audits will be completed by ADON until 3 successful consecutive months are are acheived. Variances will be reported to Quality Assurance Committee.	10/12/15 10/12/15

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F 333	Continued From page 37 and lacked evidence that Lantus was administered as ordered. On 4/29/15, the NN stated R26 had no nausea or vomiting, had a blood sugar of 54 at 4:30 PM and after 4 ounces of orange juice, the BS increased to 113. R26's doctor was called and advised to not cover with insulin per the sliding scale at the time. A NN dated 4/30/15 and timed 6:15 PM, stated R26 had no signs of distress, the BS at 4:30 PM was 56, no coverage was given, R26 was given orange juice and had no signs or symptoms of hypoglycemia. The facility failed to administer Lantus insulin twice to R26 who was an insulin dependent resident. In an interview, on 8/17/15 at 3:04 PM, E3 (ADON) confirmed the findings. 1B. On 4/18/15, R26's physician ordered a change to the sliding scale coverage with Novolog Insulin given by injection before meals based upon BS results of 0-100 = 0 units of Novolog; 101-200 = 5 units of Novolog; 201-250 = 7 units of Novolog; 251-350 = 9 units of Novolog; 351 - hi = 13 units of Novolog. On 4/20/15 R26's physician ordered, "Do not call MD for BS > 300, notify MD in book; Okay to given med pass; ^ (increase) Lantus (insulin) to 25 units q am." Review of R26's physician's orders for May 2015 revealed that the physician continued the same sliding scale coverage with Novolog insulin that was originally ordered on 4/18/15. However, the 5/14 MAR Sliding Scale Coverage for Novolog insulin for 101-200 = 5 units of Novolog had 5 units incorrectly written over with 3 units coverage for a BS result between 101 and 200.	F 333	F329 R19 1. A BMP was obtained on 8/24/15 for R19. The results were within the normal limits. 2. All residents charts were checked to ensure routine labs were completed per Medical Director's orders. 3. Consultant pharmacist was made aware and educated on the need to conduct a thorough investigation of routine labs and notify DON of any routine labs that have not been completed. New policy on routine labs initiated, RNs and LPNs were educated. See attachment #3 Labs will be monitored weekly by designee. 4. Semi-weekly audits will be completed by ADON until 3 successful consecutive months are are acheived. Variances will be reported to Quality Assurance Committee. F333 1A R26 1. Blood glucose was done on R26 on 8/17/15. 2. All residents receiving insulin were checked to ensure insulin was administered as ordered. 3. Staff members not administering Lantus as ordered were disciplined and in-serviced on administering insulin per M.D. orders. 4. Weekly audits to be completed on all residents receiving insulin until 3 successful consecutive months are achieved. DON or designee will monitor for any omission in accuracy of insulin. Variances will be reported to Quality Assurance Committee.	10/12/15 10/12/15

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F 333	Continued From page 38 R26's 5/15 MAR was reviewed and revealed the sliding scale Novolog insulin was not administered as ordered on the following dates: On 5/20/15 at 7:30 AM, R26's BS was 255 and R26 was incorrectly covered with 7 rather than 9 units as ordered. The next BS reading on 5/20/15 at 11:30 AM was 327; On 5/20/15 at 4:30 PM, R26's BS was 123 and R26 was incorrectly covered with 3 units rather than 5 units as ordered. The next BS reading on 5/21/15 at 7:30 AM was 333; On 5/24/15 at 11:30 AM, R26's BS was 180 and R26 was incorrectly covered with 3 units rather than 5 units as ordered. The next BS reading on 5/24/15 at 4:30 PM was 190; On 5/26/15 at 4:30 PM, R26's BS was 110 and R26 was incorrectly covered with 3 units rather than 5 units as ordered. The next BS reading on 5/27/15 at 7:30 AM was 268; On 5/27/15 at 4:30 PM, R26's BS was 200 and R26 was incorrectly covered with 3 units rather than 5 units as ordered. The next BS reading on 5/28/15 at 7:30 AM was 255; On 5/31/15 at 7:30 AM, R26's BS was 263 and R26 was incorrectly covered with 7 units rather than 9 units as ordered. The next BS reading on 5/31/15 at 11:30 AM was 449. NNs from 5/20/15 through 5/31/15 were reviewed and R26 had no complaints and no symptoms of hypoglycemia or hyperglycemia recorded.	F 333	F333 1B R26 1. Blood Glucose was done on R26 on 8/17/15. 2. All residents receiving insulin were checked to ensure insulin was administered as ordered. 3. Staff members who did not administer as ordered were disciplined and in-serviced on administration of insulin per M.D. orders. Education was provided on proper reading of a Sliding Scale coverage and proper transcription of M.D. orders See attachment 13 4. Weekly audits to be completed on all residents receiving insulin until 3 successful consecutive months are achieved. DON or designee will monitor for any omission in accuracy of insulin. Variances will be reported to Quality Assurance Committee.	10/12/15

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F 333	Continued From page 39 Review of R26's physician's orders for June 2015 revealed that the physician continued the same sliding scale coverage with Novolog insulin that was originally ordered on 4/18/15. R26's 6/15 MAR was reviewed and revealed the sliding scale Novolog insulin was not administered as ordered on the following date: On 6/11/15 at 11:30 AM, R26's BS was 191 and the resident was incorrectly covered with 9 units rather than 5 units as ordered. The next BS reading on 6/11/15 at 4:30 PM, was 120. NNs were reviewed. There was no NN for 6/11/15. On 7/23/15, R26's physician ordered a change to the sliding scale coverage with Novolog Insulin given by injection before meals based upon the BS results of 0-100 = 0 units of Novolog; 101-200 = 3 units of Novolog; 201-300 = 5 units of Novolog; 301-400 = 10 units of Novolog. Review of R26's physician's orders for August 2015 revealed that the physician continued the same sliding scale coverage with Novolog insulin that was originally ordered on 7/23/15. R26's 8/15 MAR was reviewed and revealed the sliding scale Novolog insulin was not administered as ordered on the following dates: On 8/7/15 at 4:30 PM, R26's BS was 107 and R26 was not covered with Novolog per the sliding scale and should have received 3 units of Novolog. The next BS reading on 8/8/15 at 7:30 AM was 247;	F 333		

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F 333	Continued From page 40 On 8/10/15 at 4:30 PM, R26's BS was 108 and R26 was not covered with Novolog per the sliding scale and should have received 3 units of Novolog. The next BS reading on 8/11/15 at 7:30 AM was 315. On 8/7/15 at 7:30 PM, R26's NN stated, "Resident vomited with food content. Moderate amount. lungs clear. Temp (temperature) 98.6. N/S (no signs) of distress. Family and doctor notified. Rechecked BS ... 207. No insulin coverage given. On 8/9/15 at 12:10 PM, R26's NN stated the resident had no nausea or vomiting and temperature was within normal range and the NN at 10:35 PM, stated, "Res (resident) had gotten 16 units of Novolog in total for breakfast and lunch. BS was 100 before dinner. 0 (No) coverage was administered for dinner." The facility failed to administer insulins, Lantus twice and Novolog nine times as ordered to R26 resulting in significant medication errors due to the frequency of the errors and the type of medication. These errors posed a potential harm to R26, an insulin dependent diabetic. In an interview, on 8/17/15 at 3:04 PM, E3 confirmed the findings.	F 333		
F 371 SS=F	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		

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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 371	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include: 1. During the initial tour of the kitchen on 8/11/15 at 8:21 AM, the deli slicers were observed to be covered by cloth. Using cloth as a cover on food contact surfaces will harbor microorganisms that may have a negative impact on health. 2. During the Stage 1 kitchen tour on 8/11/15 at 10:38 AM, it was observed that the dry storage room behind the grill lacked adequate lighting. Adequate lighting is required to minimize pest infestation. 3. On 8/11/15 at 11:20 AM, the hand sink approximately 3 inches away the grill was observed to lack a splash guard. The purpose of a splash guard is to prevent contamination of food on the grill during hand washing. Findings were confirmed with E9 (FSD) on 8/11/15 during the kitchen tour. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/15 at 4:45 PM.	F 371	F371 – Lighting in dry storage 1. Additional lighting installed in dry storage. 2. Remainder of kitchen area checked for sanitary deficiencies. Any issues found were corrected. 3. Inspections by Dietary Manager or designee will be completed. 4. Weekly inspections by the food service director or designee will be done until 3 consecutive months of sanitary conditions are achieved. Variances in audits will be reported to Quality Assurance Committee. F371 – Splash Guard 1. Splash guard was installed between grill and hand washing sink. 2. Remainder of kitchen area checked for sanitary deficiencies. Any issues found were corrected. 3. Inspections by Dietary Manager or designee will be completed. 4. Weekly inspections by the food service director or designee will be done until 3 consecutive months of sanitary conditions are achieved. Variances in audits will be reported to Quality Assurance Committee.	10/12/15 10/12/15
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 42 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to ensure that the facility's consultant pharmacist reported any irregularities to the attending physician, and the director of nursing, and these reports were acted upon for two (R13 and R19) out of 25 Stage 2 sampled residents related to laboratory tests ordered but not done for both residents. Findings include: 1. Clinical record review revealed R13 was receiving Lasix, a diuretic, due to high blood pressure and edema, as ordered since admission on 12/29/14. Review of R13's physician's orders from 1/15 through 8/15 revealed R13 had an order for a BMP laboratory test every 6 months in November and May as part of medication monitoring. The consultant pharmacist's MRR for R13, dated 5/21/15, stated "NR" (no recommendations) and failed to identify that the BMP was not done for R13 as ordered. In an interview, on 8/14/15 at 10:24 AM, E3	F 428	F428 1. BMP was completed for R13 on 8/24/15 and was within normal limits. 2. All resident charts were checked to ensure routine labs were completed per M.D. orders. Consultant Pharmacist was made aware and educated on the need to conduct a thorough investigation of routine labs and notify the DON of any routine labs that have not been completed. 3. Consultant pharmacist was made aware and educated on the need to conduct a thorough investigation of routine labs and notify DON of any routine labs that have not been completed. New policy on routine labs initiated, RNs and LPNs were educated. See attachment #3 Labs will be monitored weekly by designee. 4. Semi-weekly audits will be completed by ADON until 3 successful consecutive months are are acheived. Variances will be reported to Quality Assurance Committee.	10/12/15

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NAME OF PROVIDER OR SUPPLIER NEWARK MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 254 WEST MAIN STREET NEWARK, DE 19711	

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F 428	Continued From page 43 (ADON) confirmed the findings. 2. Cross refer to F329, example 2 Clinical record review revealed R19 was receiving daily doses of the medications Simvastatin and Januvia, for hyperlipidemia and diabetes, respectively. Although record review revealed that the consultant pharmacist completed MRRs for R19 from October 2014 through July 2015, they failed to identify and report that R19 did not have a fasting lipid profile or a HbA1C drawn for monitoring purposes in over a year and a half. Findings were confirmed by E2 (DON) during interview on 8/17/15 at approximately 2:10 PM.	F 428		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour on 8/14/15 between 9:36 AM and 11:14 AM, it was determined that the facility failed to ensure that all handrails were securely affixed to the walls. Findings include: On 8/14/15 at 10:44 AM, the wooden hand rail outside of room 216 in the hallway was observed to be loose. Finding was confirmed by E6 (FMD) on 8/14/15 at 11:14 AM.	F 468	F468 1. Hand Rail was repaired outside room 216 2. Maintenance completed an assessment of all handrails throughout the facility. No other handrails were found to be loose. 3. Random check will be completed by maintenance. 4. This detailed resident area audit (attachment #14) will be completed weekly for 100% of the rooms for 3 months to ensure the all deficiencies described for each resident area is addressed for all areas. If an audit finds that maintenance or housekeeping tasks are necessary, they will be addressed promptly by the Plant Operations Director. The Plant Operations director report findings through the QA process.	10/12/15

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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 interviews and record reviews, it was determined that the facility failed to provide laboratory services to meet the needs of its residents for quality and timeliness for two (R13 and R19) out of 25 Stage 2 sampled residents. Findings include: 1. Review of R13's physician's orders from 1/15 through 8/15 revealed R13 had an order for a BMP laboratory test every 6 months in November and May as part of medication monitoring. R13's clinical record lacked evidence that a BMP was done in May 2015. During an interview with E5 (UM) on 8/13/15 at 4:11 PM, E5 confirmed that the blood work was not obtained as ordered. In an interview, on 8/14/15 at 10:24 AM, E3 (ADON) confirmed the findings. 2. Review of the August 2015 monthly POS, originally dating back to February 2014, revealed an order for R19 to have the following blood work (labs) drawn every six (6) months: CMP, Fasting Lipid Profile, HbA1C, and Ferretin. R19's clinical record lacked evidence that any of these labs were drawn in the past year and a half.	F 502	F502 1. R13 had labs completed. HbA1C and Ferretin drawn on 8/14/15. All were found to be within the normal range. Fasting lipid panel was completed on 8/18/15 and found to be within normal range. 2. All resident charts were check for routine labs and completed per M.D. orders. The consultant pharmacist was made aware and educated on the need to conduct a thorough investigation of routine labs and notify DON of any routine labs that have not been completed. See attachment #3 3. A new policy on routine labs has been initiated. RNs and LPNs were educated. Labs will be monitored weekly by ADON or designee. 4. Semi-weekly chart checks will be completed by DON or designee for 3 months to ensure consults & assessments are completed. Any variances will be reported to quality assurance committee.	10/12/15

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F 502	Continued From page 45 The last HbA1C and CMP found in the clinical record were dated 2/11/14. The last lipid profile found was from a hospital admission on 1/17/14. There were no Ferretin results found. During an interview with E5 on 8/17/15 at approximately 9:00 AM, E5 confirmed that the blood work was not obtained as ordered. Findings were confirmed by E2 (DON) during an interview on 8/17/15 at approximately 2:10 PM.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that for one (R67) out of 25 Stage 2 sampled residents, the facility failed to maintain R67's clinical record in accordance with accepted professional standards and practices that are complete, accurate and readily accessible. Findings include:	F 514	F514 1A R67 1. R67 Bladder assessment placed on resident's chart. 2. All bladder assessments were placed in the resident's charts. 3. MDS coordinator or designee will conduct random audits to ensure placement of assessment in residents' charts. 4. Semi-weekly chart checks will be completed by DON or designee for 3 months to ensure consults & assessments are completed. Any variances will be reported to quality assurance committee.	10/12/15

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F 514	Continued From page 46 Cross refer to F315 1a. R67's clinical record lacked evidence of her bladder assessments since admission to the facility on 6/19/15. In an interview on 8/17/15 at 11:36 AM, E4 (RNAC) stated that the 6/19/15 Admission Bladder Assessment and the 7/4/15 Bladder & Bowel Continence Assessment for R67 were located in a binder in her office on the 3rd floor and not in R67's clinical record on the 2nd floor. 1b. The CNA's Resident Status Sheet for R67 for July 2015 stated under the bladder section that R67 had self control of her bladder despite documented evidence of her urinary incontinence. In an interview on 8/17/15 at 11:36 AM, E4 confirmed the findings. The facility failed to ensure that R67's clinical record was maintained in accordance with accepted professional standards and practices that are complete, accurate and readily accessible.	F 514	F514 1B R67 1. The Resident status sheet on R67 was updated with correct information. 2. All residents' status sheets have been checked for accuracy. 3. All resident status sheets are updated at care conference meeting by ADON or designee. 4. Semi-weekly chart checks will be completed by ADON or designee for 3 months to ensure consults & assessments are completed. Any variances will be reported to quality assurance committee.	10/12/15

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor Nursing Home **DATE SURVEY COMPLETED: August 17, 2015**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from August 11, 2015 through August 17, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 62. The Stage 2 survey sample size was 25.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey, completed August 17, 2015 – F164, F167, F170, F246,F253,F256,F272,F278,F309,F315, F319,F323,F329,F333,F371,F428,F468, F502 and F514.	Cross Refer to the CMS 2567-L survey, completed August 17, 2015 – F164, F167, F170, F246,F253,F256,F272,F278,F309,F315, F319,F323,F329,F333,F371,F428,F468, F502 and F514.	10/12/15

Provider's Signature _____ Title Administrator Date 10-7-15