

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to promote care for 3 (R15, R38 and R44) out of 30 sampled residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include:</p> <p>1a. On 8/27/12 at 11:30 AM, the surveyor was conducting an interview with R15. At 11:35 AM, E15 (Certified Nurses Aide-CNA) knocked and entered the room without waiting for permission to enter. Approximately 5 minutes later, E5 (nurse) opened the door while saying "knock, knock." Upon seeing a surveyor with R15, E5 stated "sorry" and backed out of the room. E5 failed to knock and wait for permission to enter</p>	<p>F241</p> <p>The signage on R15's bathroom door as well as the signage in R 38's closet door has been removed. R44 has been moved to another dining table.</p> <p>All resident rooms have been audited for signage and visible signage has been removed. The seating in the dining rooms has been checked to assure that all residents may dine simultaneously.</p> <p>Nursing and Therapy staff has received an in-service on resident dignity and posting of materials. The Nursing staff has also been in-serviced on resident dining and assisted dining to allow for resident dignity.</p> <p>The Director of Nursing and Administrator or designees will monitor compliance with knocking and entering rooms, posting of signage and resident dining. Variances will be reported to the Quality Assurance Committee.</p>	10/15/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 9-25-12

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 241	<p>Continued From page 1 R15's room.</p> <p>1b. Observation on 8/27/12 at 11:50 AM revealed signage posted on R15's bathroom door. The signage stated "Staff (R15's surname)...have (patient) sit on toilet first with clothes on...remove clothing for toileting...provide hygiene..." The facility failed to ensure that personal care notes were not posted within view of anyone entering the room.</p> <p>During an interview with E2 (Director of Nursing-DON) on 8/31/12 at 3:30 PM, E2 acknowledged that both the above issues were dignity issues for R15. Subsequent observation on 9/4/12 at 11:30 AM revealed that the signage had been removed from R15's bathroom door.</p> <p>2. Observation on 8/27/12 at 2:30 PM revealed signage posted on R38's closet door which stated, "(R38's surname)...must wear depends while she is up..." The signage, which included R38's personal care, was visible to anyone entering the room.</p> <p>During an interview with E2 (DON) on 8/31/12 at 3:30 PM, E2 acknowledged that the posted signage was a dignity issue. Subsequent observation on 9/4/12 at 11:33 AM revealed that the signage had been removed from R38's closet door.</p> <p>3. During a dining observation on 8/27/12 during the midday meal, three residents were observed seated together at a corner table. Two of the residents were observed being fed by staff. The third resident, R44 was not being fed, nor did she have any food in front of her. After one staff</p>	F 241		
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F 241	Continued From page 2 completed the feeding of one of the other residents, she then obtained R44's meal and began to feed her. The facility failed to ensure that R44 was cared for in a manner that promoted her dignity. On 9/6/12, findings were reviewed with and acknowledged by E1 (Administrator) and E2 (DON).	F 241	F248 The care plan and MDS for R40 have been reviewed and revised to accurately reflect her interests and participatory status. R40 is brought out of her room and attends activities as available (not sleeping or tube feeding). The activity care plan and participation log have been reviewed for all residents to ensure accuracy. The portion of the MDS relating to Activities will be reviewed by the Director of Nursing prior to submission to verify accuracy. The Activities Director will continually monitor resident participation and inclusion in activities. Any variances will be reported to the Quality Assurance Committee.	09/15/12
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs of one (R40) out of 30 Stage 2 sampled residents in accordance with the residents' comprehensive assessments, interests, physical, mental and psychological well-being. There was no documented evidence that R40 was provided with an activity of choice, such as being taken out of her room, having pet visits, and attending music programs. Findings include: R40 was admitted to the facility on 1/8/2008. Review of her annual Minimum Data Set (MDS) assessment, dated 6/26/12 revealed that she was severely impaired, had memory problems, and	F 248		

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F 248	<p>Continued From page 3</p> <p>was total dependent on staff for all of her activities of daily living.</p> <p>Review of R40's activities/preferences assessment found in her annual MDS, dated 6/26/12, revealed that her current interests included listening to music, spending time outdoors, and being around animals. R40's activity care plan, dated 7/31/12, stated that "resident is unable to participate in group activities due to her illness, but would still enjoy being out of her room. Resident needs the comfort and knowledge that others still care. She responds to verbal and tactile stimuli." The care plan goal included that R40 would like to spend her days in comfort and not alone or isolated even though she may not always be able to verbally respond. Approaches included providing weekly calendar, speaking to resident daily, attempting 1:1 visits often, massaging her hands, making sure the TV was on, and bringing her out of her room when possible (around 4:00 PM).</p> <p>Observations of R40 from 8/27/12 to 9/6/12 (morning or afternoon up to 4:00 PM) revealed R40 was always in her room with the TV on. R40 was observed once during this time with a physical therapy staff. R40 was never observed in any other activity during these times, or outside her room.</p> <p>Review of Activity logs from January 2012 to August 2012 revealed that R40 had not been taken outside of her room in the last eight months although other activities were noted as refused. The activity log indicated that R40 was getting the 1:1 visits (two visits each month except for none in June and five visits in August 2012).</p>	F 248		
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F 248	<p>Continued From page 4</p> <p>Review of medical records indicated that R40's POA provided the facility with documentation of his requests for R40 in every care plan meeting. R40's POA had provided the facility with documentation on 2/9/12 indicating he wanted the facility staff to take R40 out of the room more often and attend group activities even though she may not be able to participate. The documentation stated: "I would like to work some schedule for (name of resident/R40) to be included in some of the activities here at the facility. She may not actively participate, but I think she needs to see more of the other people and other scenery. Nurses and CNAs can take her out of the room and set her in the hall, the dining room, fish tank, or the front entrance vestibule".</p> <p>In an interview with E6 (Activity Director) on 9/4/12 at 1:40 PM, she stated that her staff provided 1:1 interactions for R40. E6 stated that the many refusals were noted on the activity log each month for R40 were not refusals but that R40 did not attend the activity. She stated she incorrectly coded the log. E6 also stated that it was hard to take R40 to the activities because she was either on her tube feed or sleeping.</p> <p>During a family interview with R40's POA on 9/5/12 at 9:00 AM, the family member stated that R40 was getting hand massages by the CNAs, was taken out of her room informally by the CNAs (outside her room in the hallway or by the fish tank) maybe once/week, and that R40 watched TV with him, or when she was alone in the room. He stated that R40 had the same TV channel on that he watched with her the night before, not</p>	F 248		
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F 248	<p>Continued From page 5</p> <p>changing to her preferred programs the next day. He stated he never requested R40 to be taken out after 4 PM as per the care plan. He had requested R40 be taken out of her room more often. R40's POA stated he visited R40 around 8:30 AM and 4 PM daily and had not observed R40 receiving 1:1 visits, in music programs, or seen pets in her room other than when he brought his dog from home. R40's POA stated that R40 would benefit from going outside of her room more often. He referenced letters he had written to the facility in care plan meeting to address her activity needs.</p> <p>In an interview with E8 (CNA) on 9/4/12 at 10:42 AM, she revealed that R40's husband visited R40 twice/day, around 9:00 AM and would return around dinner time about 4:00 PM. She confirmed that R40 always stayed in her room and was not taken outside of her room. On 9/4/12 at 2:20 PM, E8 stated that R40 was not able to refuse care, as she was nonverbal and had no way to tell them when she did not want things. She had no way to refuse care or activities.</p> <p>In an interview with E9 (nurse) on 9/5/12 at 3:15 PM, she indicated that resident did not leave her room. She stated R40 always stayed inside her room and that R40 "does not really do things outside her room ... she spends her time with her husband". E9 stated that the "CNAs do not take (R40) outside and her husband specifies when she lays down or when she goes to bed at night". E9 stated that R40 naps when the husband is not there. E9 stated that "she has seen (name/R40) at times, out of the room with her husband. E9 indicated that R40 "was not really responsive so that for any activities she did not know how (R40)</p>	F 248		
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F 248	<p>Continued From page 6</p> <p>could participate". E9 stated that the nurses did not get involved with the activity care plan.</p> <p>In an interview with E10 (CNA) on 9/5/12 at 3:25 PM, E10 indicated that she took R40 outside her room (by the hallway or the fish tank), or lobby sometimes when she had some time. She indicated that she did this when she had the chance, and not all time. E10 stated she worked 3 times per week and would only take her maybe once during those 3 days, time permitting, and she did not record this anywhere. E10 stated that "she had never seen R40's activity care plan, but that R40's husband told her a lot of what to do with her". E10 stated that when she took the resident out of her room, she left her there and did not stay with her, "she takes her and leave her within eye sight and went to her other duties". E10 indicated that she did R40's nails on Sundays when she was not busy.</p> <p>In an interview with E11 (CNA) on 9/5/12 at 3:35 PM, E11 stated that when she came to work the resident was in bed, she talked to her but, confirmed that she did not take the resident outside of her room, or the hallway, and had never seen R40 in the hallway when she came into the facility to work. E11 indicated that "usually (R40) was ready for her tube feed, she got her up from bed, and then R40's husband came to see her. and they placed the tube feed. When husband was visiting, the staff gave them privacy and they usually watched TV". E11 indicated that she gave the resident massages on her hands and legs. E11 confirmed she did not get involved with the activity care plan.</p> <p>The facility failed to provide an ongoing activity</p>	F 248		
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F 248	Continued From page 7 program that met R40's needs in regards to being taken outside, attending music programs and having pet visits as the assessment indicated and the family had requested. The documentation failed to show that the resident was attending activities other than 1:1 visits. The staff who cared for R40 were not aware of her activity care plan needs. Refusals were noted although the resident had no way to refuse activities.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior. Findings include: Dirty/dusty wheelchairs were observed for residents in rooms 111, 201A, 205A and 212B. Observations made on 8/27/12 at 9:55 AM revealed a high back wheelchair chair dirty for resident in room 205C. Another observation of the same chair for the resident in room 205C sitting in the dining room area on 8/31/12 at 2:41 PM revealed it was still dirty. In an interview with E17 (CNA) on 8/31/12 at 2:41 PM, E17 stated that the chairs were cleaned once every two weeks. She confirmed finding the dirty	F 253	F253 All identified wheelchairs have been cleaned. All resident wheelchairs were inspected and any dirty chairs have been cleaned. The Director of Housekeeping and Laundry will maintain a schedule and power-wash the wheelchairs every two weeks. The night shift will wipe down the wheelchairs and report any that need power-washing to the Director of Housekeeping and Laundry. Audits will be conducted weekly by the Administrator or designee and variances will be reported to the QA Committee.	10/15/12

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F 253	<p>Continued From page 8 wheelchair for the resident in room 205C.</p> <p>Observation of the chair for the resident in room 205C on 9/5/12 revealed the chair was still dirty. Observations of residents sitting in front of the 2nd floor nurses station or in their rooms, on 9/5/12 revealed chairs for residents in 201A and 212B were dirty; and in room 111 was dusty. In an interview with E5 (Nurse Supervisor) on 9/5/12, she confirmed that the chair for resident in room 212B was dirty.</p> <p>In a follow up interview on 9/5/12 at 10:31 AM, E7 (Director of Housekeeping and Laundry) confirmed that the chairs were dirty for the residents in room 201A and 212B. E7 indicated that E17 never told her that the chair for the resident in room 205C was dirty. She stated "we have a communication problem" and "we can't clean them if they don't tell us".</p> <p>E7 provided the chair cleaning schedule logs from November to July 2012 showing that CNA staff signed off that chairs were cleaned on the 11-7 shift weekly and biweekly by E7 when she took all the chairs outside the facility to clean them with a spray machine. Further review of the cleaning logs indicated that E7 failed to do the chair spraying in July 2012. Also, the chair cleaning schedule checklist for July 2012 was different than the previous checklists, resulting in some chairs not being cleaned. E7 on 9/6/12 confirmed that their chair cleaning process was not working.</p>	F 253		
F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive</p>	F 274		

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F 274	<p>Continued From page 9</p> <p>assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R28 and R38) out of 30 sampled residents the facility failed to identify the need to conduct a significant change Minimum Data Set (MDS) assessment for these residents, who had elected or revoked hospice services. Findings include:</p> <p>1. Review of the clinical record revealed that R28 was discharged/revoked from hospice services on 6/12/12. The facility failed to identify the need to conduct a significant change MDS assessment when the hospice services were revoked. Findings were acknowledged by E4 (Registered Nurse Assessment Coordinator-RNAC) during an interview on 8/28/12.</p> <p>2. Review of the clinical record revealed that R38 elected hospice services on 7/6/12. The facility failed to identify the need to conduct a significant change MDS assessment when the hospice</p>	F 274	<p>F274</p> <p>The MDS was reviewed and modified for residents #R28 and #R38.</p> <p>All MDS will be reviewed by the Director of Nursing, for accuracy in coding and significant change, prior to submission.</p> <p>The MDS Coordinator and the Director of Nursing have received additional training on MDS, Both individual attended the State program, MDS 3.0.</p> <p>The Director of Nursing or designee will monitor the MDS and variances will be reported to the Quality Assurance Committee.</p>	10/15/12
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F 274	Continued From page 10 services were elected. Findings were acknowledged by E4 (Registered Nurse Assessment Coordinator-RNAC) during an interview on 8/28/12.	F 274			
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 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:	F 278	F278 The MDS was reviewed and modified for residents R5, R21, R38 and R67. A modified MDS was transmitted. All MDS will be reviewed by the Director of Nursing or designee for accuracy in coding prior to submission. The MDS Coordinator has received additional training on MDS coding and accurate assessment. The Director of Nursing or designee will review all MDS prior to submission and findings and variances will be reported to the Quality Assurance Committee.	10/15/12	

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F 278	<p>Continued From page 11</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status for six (R5, R7, R21, R38, R62 and R67) out of 30 Stage 2 sampled residents. Findings include:</p> <p>1a. Review of R67's clinical record revealed the resident had a fall with no injury on 3/13/11. The quarterly MDS assessment, dated 6/8/11 failed to code the 3/13/11 fall. The facility erroneously coded the 6/8/11 MDS as "0" falls since the prior assessment.</p> <p>1b. Review of R67's clinical record revealed the resident had a fall with no injury on 8/15/11. The quarterly MDS assessment, dated 9/3/11 failed to code the 8/15/11 fall. The facility erroneously coded the 9/3/11 MDS as "0" falls since the prior assessment.</p> <p>Findings were reviewed and acknowledged by E1 (Administrator) and E2 (DON) during an interview on 9/6/12.</p> <p>2. Review of R38's 5/21/12 MDS assessment revealed under Section J1550 Problem Conditions that "Dehydrated" was checked off. Review of R38's clinical record, including physician notes, nurse's notes, laboratory results and meal intake records for the 5/21/12 MDS assessment review time period lacked evidence of R38 having experienced any problems with dehydration.</p> <p>On 8/31/12 at 11:35 AM, E4 (RNAC) was interviewed regarding the lack of data supporting the coding of dehydration for R38 on the 5/21/12</p>	F 278			

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F 278	<p>Continued From page 12</p> <p>MDS assessment. E4 stated that she would review R38's clinical record in order to determine why she had coded the dehydration. On 8/31/12 at 3 PM, E4 stated that she was unable to find supporting evidence for the dehydration coding and that it was a coding error.</p> <p>3. R7 had diagnoses that included heart failure, Hypertension, hyperlipidemia, thyroid disorder, stroke and depression. Review of R7's MDS (Minimum Data Set) assessment, dated 3/19/12, indicated that R7 was independent and required no set up or physical help or assistance from staff with transfer, dressing and personal hygiene. Under the section G0300, entitled, "Balance during transitions and walking" indicated that R7 was "not steady, only able to stabilize with human assistance" when moving from a seated to a standing position. R7 was also coded for having 2 or more falls without injury from the previous assessment.</p> <p>The annual MDS, dated 6/17/12, indicated that R7 required limited assistance of 1 person physical assist with transfer, dressing, and personal hygiene. R7's "Balance during transitions and walking" continued to be coded as not steady and again revealed that R7 had 2 or more falls without injury since the previous assessment (3/12/12).</p> <p>The current care plan, dated 7/30/10 for the problem entitled, "...requires variable assist for ... ADLs (Activities of Daily Living)..." dated 7/30/10, included the approaches, "1. Staff will provide set (sic) as needed for all ADLs, 2. Staff will assist resident... and provide variable assistance for transfers and to complete bath..."</p>	F 278		
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F 278	<p>Continued From page 13</p> <p>The "Resident Status Sheet" dated 2/1/12 used to direct CNA care for R7 was checked under the areas of "Dress" and "Grooming" for both "Assist" and "Total care". Position was checked for both "Change by self" and "With 1 assist".</p> <p>During an interview on 9/5/12 at 11:30 AM, R7 stated that she dresses herself but staff are always there to assist her.</p> <p>During an interview on 9/5/12 at 12:10 PM, E4 (RNAC/Registered Nurse Assessment Coordinator) and E5 (Nurse Supervisor) both stated that they felt this was a coding error. E4 stated this was a coding error with the CNAs and that she did an inservice with them on how to code. E5 stated that R7 usually needed at least supervision to 1 person assist with dressing, personal hygiene and definitely a 1 person assist with transfers. E5 stated that once set up, R7 could wash her face but stated that doing the lower part of her body and would have required some assistance. Both E4 and E5 denied that R7 had a decline in her ADL status from the 3/19/12 to 6/17/12 MDS assessments. E4 and E5 both stated that the 3/19/12 MDS assessment was in error.</p> <p>On 9/5/12 at 2:50 PM, E9 was observed assisting R7 to transfer from her recliner chair to her wheelchair. R7 was observed to be unsteady with both stance and gait and clearly needed 1 person assist.</p> <p>During an interview on 9/5/12 at 3 PM, E4 stated that the 6/2012 MDS was correct and that the 3/2012 Quarterly MDS was incorrect. E4 stated</p>	F 278		
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F 278	<p>Continued From page 14</p> <p>that she believed that she incorrectly coded the 3/2012 MDS due to the CNA documentation. She asked, "Do I complete the information as I see, correctly... or by what is documented by CNAs?" E4 stated that she had previously discussed the matter with E2 (Director of Nursing) regarding the CNA documentation and was instructed to provide inservices if needed. Despite that E4 stated she had done inservices with individual CNAs regarding the ADL flow sheets, she was not able to provide documented evidence of the coding inservices done this year. She did however, provide one in May 2011.</p> <p>The facility failed to ensure that R7's Quarterly MDS, dated 3/19/12, accurately reflected the resident's status. R7 should have been coded a "2,2" (limited assistance with 1 person physical assist for transfer, dressing, and personal hygiene).</p> <p>4. Review of R5's annual MDS assessment, dated 6/27/11, revealed under Section J1550 Problem Conditions that "Dehydrated" was checked off. Review of the hospital/interagency orders, dated 5/24/11, revealed that R5 was hospitalized for gall bladder surgery and had a medical history of coronary artery disease including a previous heart attack and heart surgery, hypertension and high cholesterol. Upon return to the facility, R5's diet was checked as, "Regular, low-fat diet for 2 weeks". There was no diagnosis of any dehydration.</p> <p>Review of R5's clinical record, including physician notes, nurse's notes, laboratory results, meal intake records and Medication Administration Record (MAR) for the 6/27/11 MDS assessment</p>	F 278		
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F 278	<p>Continued From page 15</p> <p>review time period lacked evidence that R5 had experienced any problems with dehydration. On 6/2/11, R5's physician did order, "1. Weekly weights, S/P (status post) hospitalization with < (decreased) po (oral intake) 2. Offer 8 oz H2O (water), tid (three times/day) between meals c (with) % on MAR".</p> <p>Additionally, Section J1550 Problem Conditions that "Dehydrated" was checked on the quarterly MDS dated 9/23/11, the quarterly MDS dated 12/19/11, the quarterly MDS dated 3/18/12, and the annual MDS dated 6/13/12. Again, review of the clinical record, lacked evidence of R5 having experienced any problems with dehydration.</p> <p>On 8/30/12 in an interview, E2 (DON) stated that she did not believe "Dehydrated" checked on the MDS' was accurate. E2 stated she would have been aware of a resident if there was a dehydration issue and was not aware of R5 having been dehydrated.</p> <p>The facility failed to accurately code the problem conditions sections on the MDS' from 6/27/11 through 6/13/12. On 8/30/12 in an interview, E4 (RNAC) reviewed the MDS' from 6/27/11 through 6/13/12 and noted that J1550 Problem Conditions was checked for "Dehydrated". E4 stated that she did not believe that R5 was dehydrated for a year. E4 reviewed the clinical record and acknowledged that R5 was not dehydrated. E4 stated that the physician's order, dated 6/2/11, for 8 ounces of water between meals after having his gallbladder removed was a "proactive approach" for R5. E4 stated that she miscoded the 6/27/11 MDS when she checked "Dehydrated". Also, E4 stated regarding the</p>	F 278		
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F 278	<p>Continued From page 16</p> <p>subsequent MDS' dated 9/23/11, 12/19/11, 3/18/12 and 6/13/12 that the MDS's prepopulate and she missed removing "Dehydrated" for the year which was in error.</p> <p>5. R62 was admitted to the facility on 11/29/11 with a diagnosis of dementia with psychosis. Review of the nurses' notes (NN) on 12/3/11 at 11:30 PM revealed that the nurse was, "Called to 3rd floor... due to resident's aggressive behavior toward his roommate. Resident was going to hit his roommate who was lying in his own bed... Resident hit the doorway with his Rt (right) and Lt (left) hands + (and) arms... skin tear (ST) to LT hand... ST to Rt hand top of hand..."</p> <p>Review of R62's admission MDS, dated 12/8/11, in Section E - Behavior for E0200 Behavior symptoms presence and frequency, revealed that "A. physical behavior symptoms directed toward others" and "C. other behavior symptoms not directed toward others" were both incorrectly coded as "0", indicating none.</p> <p>The facility failed to accurately code the 12/8/11 MDS. On 9/5/12, in an interview E4 (RNAC) confirmed that she miscoded both the behavioral symptoms directed towards others and not directed towards others as a "0" when it should have been coded a "1", indicating the behavior occurred 1 to 3 days.</p> <p>6. R21 had diagnoses of dementia with behaviors, psychosis, delusions and depression. On 9/20/11, R14 who also had diagnoses of dementia with behaviors and psychosis pushed and kicked R21 who fell to the floor.</p>	F 278		
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F 278	<p>Continued From page 17</p> <p>An x-ray report, dated 9/20/11 stated, "Left knee shows a subtle, nondisplaced fracture of the proximal shaft of the fibula appearing acute or recent. There is osteoporosis."</p> <p>A facility reported incident report, dated 9/20/11, was sent to the State agency and stated, "X-ray of knee resulted in left knee fracture to fibula appearing acute or recent".</p> <p>Review of the quarterly MDS, dated 11/20/11, section "J1900 Number of falls since admission or prior assessment, whichever is more recent... C. Major injury - bone fractures..." revealed it was incorrectly coded as "0", indicating none.</p> <p>On 8/31/12 in an interview, E4 (RNAC) who reviewed the 11/20/11 MDS for falls, stated that she thought that the resident did not have a fracture after the 9/20/11 incident. However, upon reviewing the x-ray report and the incident report both dated 9/20/11, E4 stated that she was in error and that the 9/20/11 incident did result in a fibula fracture and should have been coded "1" for a major injury not "0", indicating none.</p> <p>The facility failed to accurately assess R21 on the 11/20/11 quarterly MDS. On 8/31/12, findings were confirmed by E4 as noted above.</p>	F 278		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280		

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F 280	<p>Continued From page 18</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that two (R7 and R40) out of 30 Stage 2 sampled residents' care plans were reviewed and revised to address each resident's problem, changes and needs. Findings include:</p> <p>Cross refer to F248. 1. Review of R40's "Activity Preferences for Customary Routine and Activities" in her last annual MDS dated 6/26/12, indicated R40's interests included listening to music, being around animals such as pets, spending time outdoors and family or significant other involvement in care decisions.</p> <p>Review of R40's Activity care plan (with a last revision date of 7/31/12) for the problem of "Resident is unable to participate in group activities due to her illness, but would still enjoy</p>	F 280	<p>F280</p> <p>The Care Plans and corresponding flow sheets for R7 and R40 have been reviewed and revised for accuracy.</p> <p>Random audits of all resident Care Plans will be conducted by the Assistant Director of Nursing or designee on a monthly basis and modifications will be made if needed.</p> <p>The Activities Director and Assistant Director of Nursing have been counseled on the importance of accuracy in Care Planning and the need for modifications as resident status changes.</p> <p>The Director of Nursing or designee will monitor the monthly audits and findings and variances will be reported to the Quality Assurance Committee.</p>	10/15/12
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F 280	<p>Continued From page 19</p> <p>being out of her room. Resident needs the comfort and knowledge that others still care...." indicated a goal that R40 "would like to spend her days in comfort and not alone or isolated even though she may not always be able to verbally respond". The approach or intervention Section of the care plan failed to include music, being around animals such as pets, and spending time outdoors. It also failed to include requests by R40's POA on 2/9/12 care plan meetings to have her out of her room and to be included to attend activities the facility had in their activity schedule. The care plan included interventions such as providing weekly calendar, speaking to resident daily, attempting 1:1 visits often, massaging her hands, making sure TV was on, bringing her out of her room when possible (around 4PM), and an intervention box available to the resident.</p> <p>Review of the activity logs for R40 (from January to August 2012) revealed that the documents lacked documented evidence that R40 attended or had the activities required in the care plan, except 1:1 visits. The 1:1 visits were noted as two per month and August included 5 1:1 visits.</p> <p>In an interview with E6 (Activity Director) on 9/6/12, she confirmed this finding.</p> <p>Although the facility was providing some undocumented activities for R40 that were addressed in the care plan, the care plan failed to include the assessed activity pursuits of R40 and the family requested activities which included taking R40 out of her room and having her participate in facility activities.</p> <p>The facility failed to review and revise R40's care</p>	F 280		
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F 280	<p>Continued From page 20</p> <p>plan to include activities of preference completed by the staff per annual MDS dated 6/26/12 such as music, going out of her room for activities, pet visits.</p> <p>Cross refer F278 Example 3.</p> <p>2a. Review of R7's ADL (Activity of Daily Living) care plan, dated 7/30/10, included the problem/concern, "...requires minimum (crossed out) with the word, "variable" written above it and with a revision date of 2/2/12. The goal was listed as "...will be able to continue to perform routine ADLs with minimum assistance..." The listed approaches included, "1. Staff will provide set (sic) as needed for all ADLs, 2. Staff will assist resident... and provide minimum (crossed out) with the word, "variable" assistance for transfers and to complete bath. 3. Resident will be evaluated for potential decline in self caring."</p> <p>2b. R7's care plan, dated 7/2/12 entitled, "Potential for complications related to urinary incontinence" had approaches that included "...Offer/assist to toilet/bedpan... at scheduled intervals during the day: Q (every) 2 hours, before and after meals..." However, the facility failed to be specify how much assistance R7 needed for this task.</p> <p>During an interview on 9/5/12 at 12:10 PM, E4 (RNAC/Resident Nurse Assessment Coordinator) and E5 (Nurse Supervisor) acknowledged that R7's care plans for ADLs and incontinence failed to specify what "variable" meant and had not specified the amount of required assistance needed.</p> <p>During an interview on 9/5/12 at 12:15 PM, E3</p>	F 280		
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F 280	Continued From page 21 (Assistant Director of Nursing) stated that R7 liked to do everything by herself and "sometimes needs assistance, sometimes not as much" She stated that the resident would get agitated if we don't let her try to do her own care as much as possible. E3 acknowledged that R7's care plans for ADLs and incontinence failed to specify what "variable" meant and had not specified the amount of assistance required for toileting.	F 280	F309 R64 expired on 6/8/12.	
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 closed record review and interview, it was determined that the facility failed to ensure that one (1) resident (R64) out of 30 Staged 2 sampled residents, received 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. Even though the facility monitored R64's bowel movement, the facility failed to recognize the gradual and sudden change in R64's bowel status and failed to consistently implement the physician's/facility's bowel regimen. In addition to experiencing the post surgical pain from a left hip surgery, R64 also experienced abdominal pain, distention and	F 309	A sample of residents will be reviewed quarterly for bowel condition and initiation of bowel protocol. The nursing staff has received in-serving on bowel protocol and initiation. The Director of Nursing or designee will monitor the quarterly samples and findings and variances will be reported to the Quality Assurance Committee.	10/05/12

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F 309	<p>Continued From page 22 discomfort. Findings include:</p> <p>R64 had diagnoses of dementia, anxiety, acute on Chronic subdural hematoma and S/P Left hip hemiarthroplasty.</p> <p>According to R64's admission Minimum Data Set (MDS) assessments dated 4/13/12, this resident's cognitive skills for daily decision were severely impaired. Bowel pattern-(0) no constipation present</p> <p>R64 was certified to be admitted to Hospice Care on 2/6/12 and recertified again on 4/10/12 for diagnosis of debility, unspecified, with life expectancy of less than 6 months.</p> <p>R64 was admitted to the hospital on 5/20/12 for complaint of left hip pain and was diagnosed with a left hip fracture. Review of the R64's Hospital's "Interdisciplinary Patient Progress Record" dated 5/24/12, stated "no BM (bowel movement) x 4 days...Bowel Regimen, D/C (Discharge) Plans".</p> <p>According to a nurse's note dated 5/25/12, R64 was re-admitted to the facility from the hospital with a diagnosis of post surgery of the Left hip (Left Hemiarthroplasty, left femoral neck fracture. (upper part of the thigh bone).</p> <p>R64 was prescribed medications which included, Ativan 0.5 mg 1/2 tablet PO (by mouth) every day (QD) and Q 6 hrs PRN (as needed) for anxiety; Risperdal 0.25 mg PO BID (twice a day) and every 6 hours PRN for agitation; Oxycodone 5 mg PO q 4 hours PRN for pain.</p> <p>The facility initially developed/initiated a care plan</p>	F 309		
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F 309	<p>Continued From page 23 entitled, "Potential for drug related complications associated with use of psychotropic medications on 4/25/12 and was last reviewed on 5/25/12.</p> <p>The care plan goal (s) was "Will remain free of drug related complications including drug related discomfort.</p> <p>The care plan approaches included : "Observe, document, report to MD pm s/sx (signs/symptoms) of Drug related discomfort (constipation, fecal impaction...)"</p> <p>R64's medications included Oxycodone 5 mg PO q 4 hours PRN for pain. Constipation is the most common adverse reaction to this medication. The nursing implications according to the Geriatric Dosage Handbook 12th Edition included "to Monitor patient for constipation"</p> <p>According to the Collaborative Physician's Orders (PPOC) under the Hospice, signed by a RN clinician on 05/25/12 at 4:30 PM and by the attending Physician on 5/31/12, the Physician's Plan of Care included the Bowel Regimen for R64, which stated, " Bowel Regimen: Bowel regime per facility standing order".</p> <p>Review of R64's 05/2012 and 6/2012 MAR (Medication Administration Record) identified the bowel regimen as follows: Day 3 on 7-3 shift: MOM (Milk of Magnesia) 30 cc if no BM for 3 days; Day 3 (3-11) shift follow with Bisacodyl suppository 1 rectally if no results from MOM Day 4 (3-11) shift; repeat Bisacodyl suppository 1 rectally again if no results from 1st dose If second dose of Bisacodyl suppository not</p>	F 309		
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F 309	<p>Continued From page 24</p> <p>effective, Notify MD for further orders on 7-3, Day 5".</p> <p>A nurse's note dated 5/28/12 stated that "PRN (as needed) pain medication (Oxycodone) given with positive effect when pt. (patient) stated pain, but could not identify where". The 3-11 MAR documentation indicated "unable to determine".</p> <p>The CNAs ADL flow sheet reflected that R64 did not have a bowel movement in all 3 shifts since 5/25/12 through 5/28/12 (3 days). The hospital record also indicated that R64 had no bowel movements during 4 days of stay in the hospital and prior to discharge to the facility. According to the MAR, on 5/29/12 at 0625 (6:25 AM) R64 was given MOM for no BM after 72 hours and the effect was "pending". There was no documented evidence that the 3-11 PM shift monitored the bowel movement and followed the regimen with the Bisacodyl suppository as planned if no results from MOM. According to the facility's "Bowel Movement List" the dates 5/29/12 through 5/31/12 were not included and therefore failed to reflect that R64's bowel movements were monitored. However, the CNA ADL Flow Record indicated that on 5/29/12 through 5/31/12 R64 did not have any bowel movement on all 3 shifts. Again on 5/31/12 as per MAR, R64 was administered MOM for no BM after 72 hours and again the effect was pending. There was no record that the nursing staff on the 3-11 PM shift continued to follow the bowel regimen as planned.</p> <p>According to the CNA's ADL Flow Record for 05/01/12 to 05/31/12, R64 had routine bowel movement from 5/11/12 through 5/20/12 prior to</p>	F 309		
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F 309	<p>Continued From page 25</p> <p>this resident's hospital admission for surgery of the left hip. The facility's "Bowel Movement List" reflected that R64 had a gradual change in bowel movement</p> <p>According to the facility's "Bowel Movement List" record, R64 had one bowel movement documented on 6/1/12 on the 7-3 shift but failed to identify the characteristic of the stool, for example, the consistency (formed, hard, soft, watery) and size (small, medium, large) to indicate potentials for constipation and/or fecal impaction. The nursing staff failed to recognize that there was a gradual to sudden change in R64's bowel habits on May/2012 as per the facility's "Bowel Movement List" and/or CNA's ADL flow sheet.</p> <p>Again there was no documentation to indicate that the nursing staff consistently implemented the bowel regimen/protocol.</p> <p>A nurse's note dated 6/1/12 stated, "Resident was complaining of back pain @09:30 unrelieved by repositioning given Oxycodone @ 09:30".</p> <p>A nurse's note dated 6/2/12 stated "...Several attempts to get OOB (out of bed). Repositioned and toileted without effect. Oxycodone given for c/o (complaint of) severe back pain and Risperdal for increased agitation. Both effective".</p> <p>According to the nurse's note from 6/3/12 through 6/6/12, R64 continued to moan in pain holding her legs, restless, crying in pain and Resident continued to receive Oxycodone for complaint of pain, also tylenol 650 mg and or Ativan for agitation.</p>	F 309		
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F 309	<p>Continued From page 26</p> <p>A nurse's note dated 6/7/12 stated, "0315 (3:15 AM) Res. pulling at leg dsq.(dressing) Ativan given for agitation...resident moaning & holding her lower abd. (abdomen) which is slightly distended and tender to touch. Decreased BS (bowel sounds) in all 4 quadrants. No BM (bowel movements) noted in the past 3 days. Refused MOM, suppository given. 0400 (4:00 AM) No BM 0500 (5:00 AM) No BM. Abd. less distended" 0600 (6:00 AM)/MAR No BM. 1400 (2:00 PM)"Res.(Resident) continues to cry trying to get out of the chair...No BM.</p> <p>Interview with E5 (RN- unit supervisor) on 8/30/12 @ 2:00 PM, she stated that the residents' bowel movements (BM) were monitored daily through documentation by CNAs on the daily BM book found at the nurse's station. The BMs documented in the CNAs ADL (Activities of Daily Living) Flow sheet by CNAs were the accurate representation of the daily BM book found at the nurse's station.</p> <p>A nurse's note dated 6/8/12 stated "Social Work ...(Hospice) vs. (visited) with patient and LPN...R64 moaning and in terrible pain. Phone call to hospice team leader to request sending patient to ...(in hospice center) for pain and symptom manage./bed available, ambulance to transfer at 3:30 PM today....son, POA agreed to transfer to center from (facility)"</p> <p>The facility failed to recognize the gradual and sudden change in R64's bowel status and failed to consistently monitor and implement the established bowel regimen for this resident and</p>	F 309		
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F 309	Continued From page 27 placed this resident potentially at risk for constipation and or fecal impaction. A nurse's note dated 6/8/12 stated "pt. (patient) moaning c/o pain at stomach, distended, no B/S (bowel sounds) noted "Large" BM noted last shift Notified Hospice PRN Morphine sulfate given @ 1300, 1330, 1345 N.P. (Nurse Practitioner) see resident". The Nurse Practitioner documented in the Physician's Progress note dated 6/8/12, that this resident's abdomen had "no audible bowel sounds, was distended and tender". This finding was discussed and acknowledged by E2 (DON) on 9/4/12 at 10:45 AM. A nurse's note dated 6/8/12 and timed 1730 (5:30 PM) stated that R64 was ready to be transported via ambulance to the hospice unit for pain management when R64 expired and was pronounced dead at "1657" (4:57 PM). R64 died of "Complication of Multiple Falls including Left Hip Fracture and Closed Head Trauma" as per death certificate.	F 309			
F 323 SS=E	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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F 323	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible when they failed to maintain the proper function of a side rail which was very loose and posed a potential accident hazard for one resident (R3) out of 30 Stage 2 sampled residents. Additionally, there were observations of the 2nd floor storage room door and 2nd floor treatment cart that were unlocked and accessible to residents. Findings include:</p> <p>1. R3 was admitted to the facility on 9/15/10. R3's Annual Minimum Data Set assessment, dated 8/24/12, revealed that R3 was assessed as requiring extensive assistance with two person assist for bed mobility and transfer. R3's clinical record revealed that she was assessed as a high risk for falls and was care planned for falls and the use of a side rail as an enabler. Review of the August 2012 Physician's Order Sheet included a physician's order for a "Rail enabler" Dx (Diagnoses): Peripheral neuropathy, Degenerative Joint Disease, right knee status post stroke.</p> <p>On 8/28/12 at 2:25 PM, R3 was observed in bed with the left 1/2 side rail up. This side rail was observed to be very wobbly, loose and tilted forward with use. R3 stated that she used the side rail as an enabler.</p> <p>On 8/28/12, findings were confirmed with E1 (Administrator). E1 immediately informed E12 (Maintenance Director) to accompany her to R3's room. E1 and E12 examined the side rail. E1</p>	F 323	<p>F323</p> <p>The bed rail for R3 has been secured to the bed. The storage closet and treatment cart on the 2nd floor have been locked.</p> <p>The other storage areas were checked to ensure that they were locked. Bed rails have been checked for all residents.</p> <p>The Maintenance Director or designee will verify that all storage closets are locked and bed rails secure during weekly Maintenance audits, utilizing a standardized audit tool.</p> <p>The audits will be reviewed by the Administrator and any variances will be reported to the Quality Assurance Committee.</p>	7/15/12
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F 323	<p>Continued From page 29</p> <p>instructed E12 to tighten R3's side rail. E1 acknowledged that R3's loose side rail posed a potential accident hazard.</p> <p>During an interview on 9/6/12, E1 was asked if the facility had a system in place for regular maintenance checks on side rails. She stated, "No...but we will now." E1 stated that they relied on someone such as the nursing staff, to inform maintenance of any issues.</p> <p>2. Observations of the 2nd floor hallway on 8/27/12 and then on 8/31/12 at 9:43 AM revealed the door to a storage room (next to room 214) unlocked with contents accessible to residents. The contents inside the room were items such as the facility air handling unit, a Hoyer lift, two oxygen concentrators, two black bags full of items on the floor, three oxygen pumps, seven Hoyer lift batteries, and tubing supplies.</p> <p>During the environmental tour of the facility on 8/31/12 at 11:45 AM with E12 (Maintenance Director), the same storage room door was observed unlocked. E12 on 8/31/12 confirmed this door should be locked and proceeded to lock it. This posed an accident hazard to residents.</p> <p>3. Observations of the 2nd floor hallway during the environmental tour with E12 on 8/31/12 at 11:30 AM revealed a treatment cart that was locked yet the two top drawers were opened. A resident (R66) was observed sitting next to the cart. The contents of the cart drawer included medicated ointment for residents. E12 proceeded to contact a nurse (E14) on the floor.</p>	F 323		
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F 323	Continued From page 30 In an interview with E14 (Nurse) on 8/31/12 at 11:40 AM, she confirmed the finding. She indicated that although the cart appeared locked, it was not locked.	F 323	F441	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	The soiled linen was removed from room 203 on 8/27/12. The other resident bathrooms were checked for soiled linen. The Director of Housekeeping and Laundry or designee will verify that all soiled linen is bagged and removed from resident rooms by review of Housekeeping audits utilizing a standardized audit tool. The audits will be reviewed by the Administrator and any variances will be reported to the Quality Assurance Committee.	10/15/12

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F 441	Continued From page 31 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide a safe, sanitary and comfortable environment that ensured prevention of the development and transmission of disease and infection. The facility failed to bag and remove soiled bath linens from a resident's bathroom, instead of leaving it on the floor. Findings include: Observation on 8/27/12 at 11:50 AM of the bathroom in room #203 revealed unbagged, soiled bath linens on the floor. The linens had a strong odor of stool. A repeat observation at 2:20 PM revealed that these same unbagged, soiled bath linens remained on the bathroom floor along with a strong odor of stool. On 8/27/12 at 2:25 PM, E16 (CNA) confirmed that she was assigned to room #203 and was asked to check the bathroom. E16 bagged and removed the soiled bath linens and stated that this was not her usual practice.	F 441		
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	F 514		

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F 514	<p>Continued From page 32 systematically organized.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that R64's clinical record was maintained in accordance with accepted professional standards and practices that are complete and accurately documented for one (R64) out of 30 stage II sampled residents. Findings include:</p> <p>R64's care plan was revised to include 1/2 hour safety checks beginning on 5/16/12 at 1:30 AM through 5/20/12 at 10:30 PM. These safety checks were documented on the "Resident Half Hour Safety Checks" form by the CNAs.</p> <p>R64 was sent to the ER and admitted to the hospital on 5/20/12 at 11:15 AM and returned to the facility on 5/25/12 at 2 PM.</p> <p>Review of the "Resident Half Hour Safety Checks" from 12:00 PM through 10:30 PM on 5/20/12 and from 7:00 AM through 2:30 PM on 5/22/12 indicated that R64 was being checked every half hour even though the resident was not in the facility.</p> <p>The facility failed to accurately document the</p>	F 514	<p>F514</p> <p>R64 has expired.</p> <p>A random audit of resident safety checks will be conducted by the Assistant Director of Nursing on a monthly basis.</p> <p>Nursing Assistants have been educated and counseled about the importance of accurate documentation.</p> <p>The Director of Nursing or designee will randomly monitor the C.N.A. documentation. Findings and variances will be reported to the Quality Assurance Committee.</p>	10/15/12
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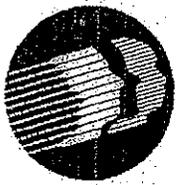
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 33 "Resident Half Hour Safety Checks" for R 64.	F 514		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLETED: September 6, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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<p>01</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An annual and complaint survey was conducted at this facility from August 27, 2012 and concluded on September 6, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 62. The survey stage 2 sample totaled 30 residents which also included three (3) closed records.</p> <p>Skilled and Intermediate Care Nursing Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p>	<p>Cross Reference to CMS 2567-L</p> <p>F241, F248, F253, F274, F280, F309, F323 F441 and F514. <i>10/15/12</i></p>
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Provider's Signature *[Signature]* Title Administrator Date 9-25-12



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Page 2 of 2

NAME OF FACILITY: Newark Manor

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Cross refer to the CMS 2567-L survey report date completed 9/6/12, F241, F248, F253, F274, F278, F280, F309, F323, F441 and F514.