



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085027</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2012</b>
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F 241	<p>Continued From page 1</p> <p>12:40 PM (35 minutes later) R22 was served her lunch.</p> <p>3. On 6/4/12 at 12 :00 PM R22, R40, and R27 were observed sitting at the same table for lunch. At 12:01 R22 was served her lunch. At 12:07 PM R98 arrived for lunch and sat at the same table. At 12:25 PM (24 minutes later) R40 and R27 were served their lunch. At 12:32 PM (25 minutes later) R98 was served her lunch.</p> <p>4. On 6/4/12 at 12:00 PM R47, R162 and R123 were observed sitting at the same table for lunch. At 12:05 AM R123 was served her lunch. At 12:24 PM (19 minutes later) R162 was served her lunch. At 12:34 PM (25 minutes after she arrived and while her table mates were eating) R162 was served her lunch.</p> <p>5. On 6/4/12 at 12:11 PM in the main dining room R103 was observed eating while three residents at the table did not have their lunch yet. At 12:19 PM, 8 minutes later, R12 and R119 received their lunch. At 12:24 PM, 13 minutes after the first resident was observed eating lunch R80 received her lunch.</p> <p>6. On 6/4/12 at 12:15 PM in the main dining room R139 was observed eating lunch. At 12:23 PM, eight minutes later, R31 who was sitting at the same table received his lunch.</p> <p>7. On 6/4/12 at 12:17 PM in the main dining room R29 and R109 were observed eating lunch. At 12:24 PM, 12 minutes later R164 who was sitting at the same table received her lunch.</p> <p>8. On 6/4/12 at 12:17 PM in the main dining room</p>	F 241	<p>Residents identified continue to have their dignity and respect maintained during meals service, use of clothing protectors and knocking on doors. Observations have been completed to ensure no others have been affected.</p> <p>In-servicing shall be completed on or before July 18, 2012 for facility staff on Resident Rights, Dignity and Respect.</p> <p>Rounds shall be completed weekly over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12
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F 241 Continued From page 2  
R56 was observed eating lunch, At 12:27 PM, 10 minutes later, R44 who was sitting at the same table received her lunch.  
The following dining observation was made in unit 1 on 5/30/12

9. R26 was dining in her room. When the aid was setting up the tray for R26, she applied the clothing protector without any indication to R26 that she was doing so.

10. R104 was dining in her room. When the aid was setting up the tray for R104, she applied the clothing protector without any indication to R104 that she was doing so.

11. On 5/30/12, 5 CNA's (E11, E13, E14, E15 and E16) were observed entering resident rooms in the 200 hall with lunch trays; the CNA's knocked and entered resident rooms without waiting for a response or permission to enter. Additionally, a student nurse (E17) took a tray into resident room 215A without first knocking.

12. On 6/4/12, the Unit 2 Manager (E18) and one CNA (E19) entered resident rooms in the 200 hall with lunch trays; they knocked and did not wait for a response before entering the rooms.

13. During the lunch meal observation on 5/30/12 on Station 2, R130 received her lunch in her room at 12:24 PM. E11 (CNA) assisted R130 and applied a clothing protector around her neck without first asking if the resident desired one.

14. A second dining observation was completed on Station 2 on 6/4/12. At 12:04 PM, E11 entered R44's room with a meal tray while knocking on the door. E11 failed to wait for permission to enter.

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F 241 Continued From page 3  
the room. R44 was not offered a clothing protector and had to ask E11 for one.

F 241

At 12:07 PM, E11 entered R77's room with a meal while knocking on her door and not waiting for permission to enter. E11 then applied a clothing protector around R77's neck without asking if the resident desired one.

F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS  
SS=E

F 272

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;  
 Medications;  
 Special treatments and procedures;  
 Discharge potential;  
 Documentation of summary information regarding

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F 272	Continued From page 4 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 review and interview it was determined that the facility failed to have accurate and complete documentation on the MDS for four (R235, R162, R2, and R4) out of 51 sampled residents. Findings include:  1. R235 was admitted to the facility on 4/24/12. An Admission MDS dated 5/2/12 was completed. R235 returned to the facility on 5/25/12. The facility incorrectly initiated a new Admission MDS dated 6/1/12 instead of a Readmission Assessment.  The care area assessment (CAA) for the 5/2/12 MDS triggered for activity concerns and the facility documented they would proceed with a care plan. A care plan (CP) for activities was initiated on 5/4/12 and closed as resolved on 5/21/12 after the resident was hospitalized on 5/17/12. This resulted in the resident not having the activity care plan from 5/25/12 until 6/5/12.  An interview on 6/5/12 at 8:55 AM with E5 (RNAC) revealed that the 5/2/12 MDS should not have been coded as a new admission when it	F 272	Residents identified have been reviewed by the ICP team and significant correction MDS's have been completed where able. Current residents shall have MDS's reviewed prior to submission for accuracy.  In-servicing shall be completed for the RNAC and staff completing the MDS's on accuracy of MDS's on or before July 18, 2012.  Random audits shall be completed monthly for 90 days to determine compliance with documentation. This shall be the responsibility of the DON/designee.  The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	7/18/12	

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F 272 Continued From page 5  
was actually a re-admission. This resulted in the original care plans not being available on the electronic record and the facility had to go through the process of initiating new care plans. R235 had no activity care plan from 5/25 to 6/5/12 due to the incorrect assessment type.

2. R162 was originally admitted to the facility on 4/29/11. An admission minimum data set assessment (MDS) dated 5/6/11 was completed. The resident went to the hospital on 12/24/11 and returned on 12/31/11. The facility initiated another admission MDS assessment dated 1/7/12 instead of a re-admission assessment.

An interview on 6/5/12 at 8:55 AM with E5 (RNAC) confirmed a new admission MDS should not have been completed after the hospitalization.

3a. R2 was admitted to the facility on 3/29/12. Review of the nursing admission assessment that was documented in the facility's computer, revealed she was admitted with a stage 2 pressure. Review of R2's wound sheets revealed she was assessed on 3/29/12 with a stage 2 and a stage 3 pressure ulcer.

Review of R2's admission MDS dated 4/15/12 documented she was admitted with a stage 2 pressure ulcer only.

On 5/31/12 at 10:30 AM interview with E2 (DON/wound nurse) revealed she assessed R2's wound when she was admitted with a stage 2 and a stage 3 pressure ulcer. Review of R2's MDS with E2 confirmed R2's MDS did not accurately document R2's pressure ulcers.

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F 272	<p>Continued From page 6</p> <p>3b. R2 was admitted to the facility with diagnoses that required interventions and/or monitoring which included anxiety, depression, gastroesophageal reflux, hypothyroidism, anemia, diabetes mellitus, asthma and obstructive sleep apnea that were not added to her 4/15/12 MDS.</p> <p>Review of the area on the MDS that documented "other" had ICD-9 codes listed without a written diagnoses to go with them.</p> <p>Review of R2's MDS with E5 (RNAC) on 6/5/12 at 11:45 AM revealed E5 retrieved her information for the MDS by looking at what was documented in the computer she did not go look at the paper chart to pick up the stage 3 pressure ulcer or all R2's active diagnoses should have been included and listed on her MDS.</p> <p>4. R4 was admitted to the facility with diagnoses including head injury, contractures, aphasia, depression, quadriplegia and dementia with delusions.</p> <p>Review of R4's annual MDS, section M, dated 1/30/12, stated that R4 was not at risk for pressure ulcers and he had no other ulcers, wounds and skin problems. The quarterly MDS, section M, dated 4/30/12, also stated that R4 had no other ulcers, wounds and skin problems.</p> <p>Observation of R4's leg on 5/31/12 revealed multiple raised red areas/rash covering the tibial area of the right leg with 4 scabbed abrasions and an open ulceration on the ankle where a surgical pin protruded.</p> <p>Review of R4's June 2012 monthly physician</p>	F 272		

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F 272 Continued From page 7  
order sheet revealed an order to "monitor open area on right leg and metal appliance sticking out daily -leave open to air" (initiated on 10/18/11). The order was reflected on the monthly treatment administration record (TAR) and on R4's care plan (initiated on 7/26/11).

F 272

F 279 After reviewing the MDS data, E12 (RN) confirmed that the information in section M was incorrect and R4's skin condition was omitted.  
SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

F 279

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

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

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

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

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F 279	<p>Continued From page 8</p> <p>determined that the facility failed to develop care plans for two (R166 and R146) out of 51 residents sampled. Findings include:</p> <p>1. R166 was admitted to the facility on 2/21/12 with a stage 2 pressure ulcer (PU) on the right (R) side of the coccyx. This was reflected in the 14 day MDS and the facility checked that pressure ulcers were addressed in the care plan.</p> <p>Review of skin integrity reports for R166 revealed that the R coccyx PU resolved on 3/7/12. On 3/21/12, a stage 2 PU developed on the left buttock and it was resolved on 3/29/12. Also on 3/21/12, a stage 2 PU developed on the coccyx/inner buttock which was still present when the resident expired on 4/12/12.</p> <p>Review of Physician orders revealed that R166 developed arterial wounds on his feet in March 2012 for which he received treatment.</p> <p>Despite R166 being admitted with a PU, the development of new PU's and arterial wounds, the facility care planned that R166 was at risk for skin breakdown. However the failed to develop a care plan for the actual PU's/arterial wounds.</p> <p>Findings were confirmed with E2 (Director of Nursing) during an interview on 6/5/12.</p> <p>2. Review of R146's physician orders revealed she had a physician order dated 5/10/12 for Alprazolam 0.25 mg one tablet by mouth twice daily for increased anxiety.</p> <p>Review of R146's MAR (Medication Administration Record) revealed R146 was</p>	F 279	<p>Resident R 166 no longer resides at the facility. Resident R 146 has been reviewed by the ICP team and the plan of care has been reviewed and updated as necessary to reflect the resident's current level of care. Current residents plans of care shall be reviewed at their next scheduled care conference to determine compliance.</p> <p>In-servicing shall be completed before July 18, 2012 for licensed nursing staff on Care Planning</p> <p>Random audits shall be completed monthly for the next 90 days to determine compliance. This shall be the responsibility of the DON/designee</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12	

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F 279	Continued From page 9 administered Alprazolam 0.25 mg twice a day for anxiety.  Review of R146's care plans revealed the facility failed to develop a care plan with interventions for R146's diagnoses of anxiety that required the use of the Alprazolam.  Review of the above findings with E8 (RN unit manager) on 6/5/12 at 10:20 AM confirmed the facility failed to develop a care plan for R146 with interventions related to her anxiety.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  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.  This REQUIREMENT is not met as evidenced	F 280		

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F 280 Continued From page 10  
by:  
Based on record review and interview it was determined that the facility failed to ensure for one (R143) out of 51 sampled residents, the care plan had been revised when changes in care were implemented. Findings include:

Cross refer F314.

R143 had a care plan titled "Resident is at risk for skin breakdown as evidenced by immobility developed and initiated on 3/31/12 included a goal that R143 will not show signs of skin breakdown for 30 days. Interventions included:

- Assist resident in repositioning q (every) 2 hrs (hours).
- Encourage resident to consume all fluids during meals.
- Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation.
- Evaluate for skin risk factors per protocol.
- Monitor skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not easily blanche easily.
- Norton/Braden assessments per policy.
- Pressure redistribution surfaces to bed and chair per protocol.
- Weekly skin assessment by licensed nurse.

In addition, R143 had a care plan for actual skin breakdown related to recent surgery initiated on 3/29/12 with goal that wound would remain free from signs and symptoms of infection for 30 days.

Although R143 had an onset of a reddened area of the left achilles on 4/8/12 and a new unstageable pressure ulcer (PU) with necrosis

F 280

Resident R 143 remains in the facility and has been reviewed by the ICP team. R 143's plan of care has been reviewed and updated as necessary to reflect the resident's current level of care. Current residents have been reviewed to determine that appropriate care plans related to wounds are in place.

In-servicing shall be completed before July 18, 2012 for licensed nursing staff on Care Planning.

Random audits shall be completed monthly for the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

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F 280	<p>Continued From page 11</p> <p>and suspected deep tissue injury (DTI) of the left achilles secondary to the left knee immobilizer, the record lacked evidence of a care plan for this new PU.</p> <p>On 6/6/12, the surveyor was provided a copy of a revised care plan for the actual skin breakdown which included the new PU of the left achilles. The care plan documented "4/9/12 DTI noted to posterior left ankle related to inability to remove left knee immobilizer for pressure relief, only for skin checks and to do tx (treatment) to left knee. Resident is confused and will not keep knee straight without immobilizer. 4/25/12 soft necrotic tissue present left ankle-chemical debridement with Santyl initiated 5/24/12 Surgical debridement performed by podiatrist."</p>	F 280		
F 309 SS=D	<p>Findings were reviewed with E1 (Administrator), E2 (Director of Nursing), and E22 (Manager of Clinical Operations) on 6/7/12 at approximately 3 PM.</p> <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>other documentation as needed it was determined that the facility failed to ensure that two (R143 and R4) out of 51 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. The facility failed to assess R143's abdomen for a period of more than 72 hours with no bowel movement and failed to document the outcome of an intervention. The facility failed to accurately assess and document R4's wound and rash. Findings include:</p> <p>1. R143 was admitted to the facility on 3/29/12 with diagnoses including fracture of left elbow(status post left radial head replacement on 3/26/12 ) and left patella (open left knee extensor tendon repair on 3/26/12), alcoholism, peripheral vascular disease (PVD), coronary artery disease, congestive heart failure, dementia, history of myocardial infarction, and hypertension.</p> <p>The admission Minimum Data Set (MDS) assessment dated 4/5/12 documented that R143 required extensive assistance of two plus staff persons for bed mobility, transfers, dressing, toilet use, personal hygiene, and did not ambulate.</p> <p>Review of the facility's policy titled "Bowel Protocol" documented "1. Each evening the 3-11 nurse will review CNA records to identify residents who have no recorded BM on the CNA record for greater than three consecutive days. An assessment will be done to determine if there is a need for an intervention."</p> <p>Review of the certified nursing assistant (CNA)'s</p>	F 309	<p>Resident R 143 remains in the facility. The resident's bowel records are monitored daily and treatment is provided if there is no BM x 3 days. Current residents have been audited with no issues identified. Current residents shall be monitored daily and treatment shall be provided per physician orders if no BM noted in 3 days. Resident R 4 remains in the facility and continues to have a weekly skin assessment documented. Monitoring is in place for the left ankle as ordered by the physician. Current residents have been reviewed and no issues were identified.</p> <p>In-servicing shall be completed by July 18, 2012 for licensed nursing staff on skin assessment, documentation, physician orders, and facility BM protocol.</p> <p>Random audits shall be completed monthly for the next 90 days to determine compliance with documentation of skin assessments and documentation. Daily audits shall be completed over the next 90 days to determine compliance with facility bowel protocol. This shall be the responsibility of the DON/designee</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12

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F 309	<p>Continued From page 13</p> <p>documentation of bowel activity for May 2012 revealed no documented bowel activity beginning on evening shift on 5/2/12 through the evening shift on 5/7/12 for total of 16 shifts.</p> <p>Review of the nurses notes from 5/5/12 through 5/6/12 lacked evidence of an abdominal assessment to determine need of an intervention for bowel activity.</p> <p>The May 2012 Medication Administration Record (MAR) revealed Miralax 17 grams was administered: - 5/5/12 at 4:30 PM - 5/6/12 at 4 PM</p> <p>Although the above medication was administered, record review lacked evidence of the effectiveness for both of the administrations.</p> <p>Further review of the May 2012 MAR revealed that R143 was administered Dulcolax 10 mg. suppository and R143 had a documented BM during the night shift on 5/7/12.</p> <p>Findings confirmed with E12 (nurse) on 6/7/12 at approximately 10 AM.</p> <p>2. R4 was admitted to the facility with diagnoses including head injury, contractures, aphasia, depression, quadriplegia and dementia with delusions.</p> <p>Observation of R4's leg on 5/31/12 revealed multiple raised red areas/ rash covering the tibial area of the right leg with 4 scabbed abrasions and an open ulceration on the ankle where the surgical pin protruded.</p>	F 309		
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F 309	Continued From page 14  Review of R4's records revealed a June 2012 monthly physician order sheet revealed an order to "monitor open area on right leg and metal appliance sticking out daily -leave open to air" (initiated 10/18/11).  A care plan of the right ankle skin opening for R4, initiated on 7/26/11, included interventions for: 1) weekly round assessment and measurements and 3) evaluate wound area daily including surrounding tissue and presence or absence of drainage/infection and /or new wound pain and report to MD as indicated.  R4's treatment administration record (TAR) revealed that a skin assessment was to be done every Wednesday by the 11-7 nurse. The TAR also contained a daily wound monitor site section. Review of the February-May 2012 TARs revealed a weekly score of (3): previously noted skin injury/wound- see updated skin integrity report. There was no documentation on the daily monitor site section. There were no skin integrity reports found in R4's records for 2012. Nurses's notes also lacked evidence of measurements or assessments of the condition of the ankle wound and leg.  During an interview with R4's nurse E7(LPN) on 5/31/12, she stated the skin integrity report was initiated by the unit nurse and kept in the wound book in E2's (Director of Nursing) office. R4's care plan and TAR scores were reviewed with E7 on 6/4/12 and she confirmed that the "3" score on R4's open ankle wound required documentation and there was none in R4's record.	F 309			

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F 309 Continued From page 15  
E2 (DON) was interviewed on 6/5/12. The facility's Skin Integrity Management policy was reviewed as well as the findings in R4's records. The policy stated under Procedure: perform wound observations and measurements and complete Skin Integrity Report upon initial identification of altered skin integrity, weekly and with any deterioration of wound. E2 confirmed there was no evidence of skin reports for R4 in the wound book. A memorandum on documentation on the TAR weekly skin assessments was posted on all units (nurse signatures required). E2 confirmed that the open area on R4's ankle that was scored a "3" was not assessed according to facility policy or the physician's order.

F 309

The facility failed to follow R4's plan of care and failed to consistently assess his ankle wound and skin problems on the right leg.

F 314 SS=G 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:  
Based on record review, interviews, and review of facility's policy and procedures, it was

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F 314	<p>Continued From page 16</p> <p>determined that the facility failed to ensure that one (R143) out of 51 sampled residents who entered the facility without pressure sores did not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. R143 was assessed at risk for development of a pressure ulcer (PU) and on 4/8/12, R143 had a new PU of the left posterior ankle (achilles) secondary to the pressure from the knee immobilizer. The facility failed to consult the orthopaedic surgeon (who ordered the immobilizer), failed to reassess and implement interventions to relieve pressure to the area. These multiple system failures resulted in the PU worsening to an unstageable necrotic PU requiring debridement by a podiatrist. Findings include:</p> <p>1. R143 was admitted to the facility on 3/29/12 with diagnoses including fracture of left elbow (status post left radial head replacement on 3/26/12 ) and left patella (open left knee extensor tendon repair on 3/26/12), alcoholism, peripheral vascular disease (PVD), coronary artery disease, congestive heart failure, dementia, history of myocardial infarction, and hypertension.</p> <p>The admission Minimum Data Set (MDS) assessment dated 4/5/12 documented that R143 required extensive assistance of two plus staff persons for bed mobility, transfers, dressing, toilet use, personal hygiene, and did not ambulate. In addition, R143 was at risk for developing a pressure ulcer (PU) , but did not have a PU on the left lower extremity at the time of the assessment. CAA (Care Area Assessment) triggered for PU and a care plan was initiated.</p>	F 314	<p>Resident R 143 remains in the facility. Resident R 143 has been reviewed by the ICP team and the plan of care has been reviewed and updated as necessary to reflect the resident's current level of care. Weekly skin checks are in place and being completed and documented. The immobilizer has been discontinued per physician orders. Current residents with immobilizers/splints shall have every shift skin checks and weekly skin checks completed by a licensed nurse and documentation shall be on the TAR. Any resident identified with a skin issues shall have the physician/dietician/rehab notified. The plan of care will be developed to reflect the skin issue.</p> <p>In-servicing shall be completed by July 18, 2012 for licensed nursing staff on skin assessment, physician, dietician, and rehab notification, splints and immobilizers, documentation, and care planning.</p> <p>Audits shall be completed daily for the next 30 days then weekly times 60 days to determine compliance with skin assessment and documentation. This shall be the responsibility of the DON/designee.</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12
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F 314 Continued From page 17

Review of the admission nursing assessment dated 3/29/12 documented that R143 had mild edema of LUE (left upper extremity) and LLE (left lower extremity) and did not have any skin impairment of bilateral foot, heels, and ankles. The facility's policy and procedure titled "Skin Integrity Care Delivery Process" indicated that all residents will be assessed for potential loss of skin integrity by using the Braden Scale for predicting PU on admission/re-admission, quarterly, and with any significant change in condition. In addition, this document contained guideline titled "Pressure Ulcer Prevention Guideline" which included " Basic Prevention Interventions for all patients at risk" stated:

- Perform daily observation of the skin.
- Provide padding for casts, braces, and splints.
- Avoid/limit skin to skin contact, friction, or shearing forces. May use pillows, heels, elbow protectors to keep bony prominences from rubbing.

R143 was assessed as "mild risk" on admission (3/29/12) and on 4/7/12 utilizing the Braden Scale.

The admission physician's orders dated 3/29/12 included:

- "Skin checks weekly. Brace to LUE at all times, immobilizer to LLE at all times. Remove for hygiene-do not bend knee. Cleanse incision to LUE and LLE with betadine daily. Do not remove. NWB (No weight bearing) LLE. Skin prep. to right popliteal blister BID (twice daily)."

The care plan titled "Resident is at risk for skin breakdown as evidenced by immobility developed and initiated on 3/31/12 included a goal that R143 will not show signs of skin breakdown for 30 days. Interventions included:

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F 314	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- Assist resident in repositioning q (every) 2 hrs (hours).</li> <li>- Encourage resident to consume all fluids during meals.</li> <li>- Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation.</li> <li>- Evaluate for skin risk factors per protocol.</li> <li>- Monitor skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanch easily.</li> <li>- Norton/Braden assessments per policy.</li> <li>- Pressure redistribution surfaces to bed and chair per protocol.</li> <li>- Weekly skin assessment by licensed nurse.</li> </ul> <p>Review of the Treatment Administration Record (TAR) for April 2012 revealed that the weekly skin checks scheduled for 4/5/12 were blank, thus, lacking evidence that the skin check was completed. In addition, review of the nurses notes (N.N.) for 4/5/12 lacked evidence that the skin check was completed per the above care plan.</p> <p>Interview with E2 (Director of Nursing) on 6/5/12 at 10:30 AM confirmed that the facility failed to complete the weekly skin assessment on 4/5/12.</p> <p>Further review of the April 2012 TAR documented a new intervention to "Monitor skin above left heel daily." An interview with E20 (nurse) who initiated this intervention on 6/5/12 at approximately 3 PM revealed that the area above the left ankle became red in color due to the immobilizer hitting and rubbing the area above the heel. E20 further verbalized that she applied skin prep. and pad to the affected area.</p> <p>Per the facility's above policy, when a skin</p>	F 314		
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integrity impairment is identified the following processes are to be initiated:

- report on the 24 hour summary report.
- complete a " Skin Integrity Report ."
- interdisciplinary care plan (ICP) to include approaches to stabilize or improve co-morbidities and interventions limiting the effects of risk factors associated with PU.
- notify dietician for actual wounds.
- notify therapy department of actual wounds (e.g. pressure ulcer, venous ulcers, arterial ulcers, or diabetic ulcers which may respond to intervention) or
- risk factors including impaired mobility, seating and positioning deficits, or swallowing deficits.

Although R143 had a new skin impairment of the left achilles on 4/8/12, record review lacked evidence of a "24 hours summary report", "Skin Integrity Report, ICP, notification of dietician, notification of therapy department. Record review and staff interviews lacked evidence that the facility implemented interventions to relieve pressure from R143's left achilles PU.

On 4/9/12, a "Skin Integrity Report" was initiated which documented a new skin impairment of the left heel. Type of wound was noted as pressure and under other wound type, "DTI" or deep tissue injury. Stage of the PU was documented as "unst." or "unstageable." Appearance of the PU was documented as "necr." or necrotic with dimensions of 4.5 cm. (centimeter) length (L), by 6 cm. width (W), and depth (D) as "unk" or unknown.

On 6/4/12 at 11 AM, an interview with E21, the nurse who initiated the above "Skin Integrity Report" on 4/9/12 revealed that the above area

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F 314	<p>Continued From page 20</p> <p>was discolored and skin hard to touch and not supple. The physician was notified and family, however, there was no evidence of this in the record. E21 indicated that when she did the daily treatment to the left knee surgical site prior to 4/9/12, E21 did not do the entire leg.</p> <p>Despite the fact that R143's left achilles PU worsened with necrosis with the above dimensions on 4/9/12, record review again lacked evidence of a "24 hour summary report", "Skin Integrity Report, ICP, notification of dietician, notification of therapy department. In addition, the facility failed to reassess the interventions, implement a care plan for the new PU, and failed to implement interventions to relieve pressure caused by the immobilizer.</p> <p>An interview with E24 (Registered Dietician) on 6/11/12 at approximately 11 AM confirmed that E24 was not contacted regarding the new PU, however, E24 became aware of the PU during routine dietician review. An interview with E25 (Director of Therapy Services) on 6/11/12 at approximately 12:27 PM revealed that the Therapy Department was notified during a weekly Utilization Review meeting on 4/11/12 that R143 was being treated for a wound on the left achilles.</p> <p>An interview with E13 (Certified Nursing Assistant) on 6/7/12 at approximately 8:20 AM revealed that she recalled that there was a blister in the area of the left ankle due to immobilizer rubbing in the area. E13 indicated that when R143 was given a bath, E13 removed the immobilizer and the resident was not combative. E13 further verbalized that when R143 was in bed, the immobilizer moved and would move down lower to the leg, thus, E13 needed to pull</p>	F 314		
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F 314	<p>Continued From page 21</p> <p>the immobilizer up the leg to ensure proper placement. In addition, E13 reported that a shorter length immobilizer was obtained which was currently being utilized.</p> <p>Review of the Physician's Order dated 4/9/12 timed 10:40 AM documented "skin prep. to DTI, left posterior ankle q. shift X 14 days then re-evaluate. Remove left knee immobilizer and LUE immobilizer q shift to monitor skin integrity."</p> <p>Subsequent assessments on the "Skin Integrity Report" were completed by E2 which documented the continued appearance of necrosis with no depth from 4/12/12 through 5/3/12. An interview with E2 on 5/29/12 at approximately 8:28 AM revealed on 4/9/12, the left posterior ankle PU was first identified as unstageable DTI with appearance discolored-darker than other parts of her body/different consistency than other skin, intact, and softness. The PU was secondary to the leg immobilizer.</p> <p>On 4/16/12, R143 had a follow-up appointment with the orthopaedic surgeon. Subsequent to this appointment, physician's orders were obtained and implemented on 4/16/12 which included "ROM (range of motion) of left straight leg raises in brace if tolerated. Left knee, keep in immobilizer. Do not bend."</p> <p>Although R143 had acquired a new PU secondary to the immobilizer, record review lacked evidence that the orthopaedic surgeon was informed and consulted.</p> <p>An interview with staff at the orthopaedic</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>surgeon's office on 6/5/12 at approximately 4:30 PM revealed that during the follow-up visit on 4/16/12, they were not informed of the PU of the left achilles.</p> <p>Physician's order dated 4/22/12 documented "D/C (discontinue) skin prep. to left posterior ankle, clean left posterior ankle with wound cleanser, pat dry, apply sure prep. to surrounding wound edges, apply Hydrogel to wound bed, cover with gauze and secure. Change dressing daily and PRN (as needed)."</p> <p>Subsequent assessments on the "Skin Integrity Report" were completed by E2 which documented the continued appearance of necrosis with no depth from 4/12/12 through 5/3/12. Beginning on 5/10/12, the PU had depth of 0.2 cm. and on 5/17/12, the tendon was exposed.</p> <p>On 5/14/12, a consultation with a podiatrist was ordered for possible debridement of left ankle. Review of the "Report of Consultation" dated 5/24/12 documented that the podiatrist debrided the necrotic tissue from the left achilles with new wound care orders for Hydrogel daily was implemented. Subsequent "Report of Consultation" dated 6/4/12 by the podiatrist included recommendation to "continue wound care with Hydrogel and to continue to offload and avoid pressure from knee brace."</p> <p>Subsequent interview with E21 on 6/7/12 at approximately 9:10 AM revealed that the knee immobilizer that R143 was initially admitted with was too long and had to be pulled up to R143's thigh area because the immobilizer kept sliding</p>	F 314		
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F 314	<p>Continued From page 23</p> <p>down R143's leg. E21 verbalized that a piece of yellow foam was obtained from therapy which was placed in the immobilizer to minimize the friction to the left achilles area. E21 did not recall whether the skin impairment was present in the left achilles prior to obtaining the foam. Lastly, E21 verbalized that she does not recall a blister or a reddened area prior to 4/9/12 and that the first time she observed the skin impairment was on 4/9/12.</p> <p>A meeting with E1 (Administrator), E2 (DON), E22 (Manager of Clinical Operations), and E23 (Senior Clinical Education Specialist) on 6/7/12 at approximately 11:45 AM revealed that they interviewed E13 who verbalized that R143 had a blister in the left achilles area. In addition, E13 verbalized that the previous knee immobilizer was in the laundry department. This immobilizer was obtained and E23 verbalized that it was likely that this immobilizer was causing the pressure on the left achilles area. In addition, E23 verbalized that if there was a blister, it could have been a stage II PU or suspected DTI. E23 related that whether this was a stage II PU or suspected DTI, pressure relief would have been indicated.</p> <p>Above findings were reviewed with E1 (Administrator), E2 (Director of Nursing), and E22 (Manager of Clinical Operations) on 6/7/12 at approximately 2 PM.</p> <p>On 6/7/12 at approximately 3 PM, the surveyor was given a written statement by E2 which documented E2's recollection of the PU observed on 4/12/12 : wound was located on the posterior ankle at the achilles on the left foot. The wound presented as intact, discolored, firm skin with a</p>	F 314		

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F 314	Continued From page 24 spongy/boggy feel to the center of the wound under the firm skin."  A subsequent interview with a staff member at the orthopedic office on 6/7/12 at approximately 3:48 PM revealed that if the treating physician was informed of the pressure caused by the immobilizer and consulted, adjustments to the immobilizer could have been completed.	F 314		
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		

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F 329	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that for two (R144 and R146) out of 51 sampled residents, the facility failed to ensure that the resident's drug regimens were adequately monitored. Additionally for R144 the facility failed to conduct an AIMS test on admission. Findings include:</p> <p>1. R144 had admission physician orders, dated 5/25/12, including psychotropic medications Alprazolam 0.25 mg by mouth 3 times a day (for anxiety) and Abilify 2 mg by mouth daily. Abilify, an antipsychotic, requires an AIMS on admission and every 6 months, although ordered for R144 for depression.</p> <p>Review of R144's care plan, dated 5/26/12, for at risk for complications related to the use of psychotropic medications listed an intervention to "complete behavior monitoring flow sheet... monitor for continued need of medication as related to behavior and mood...". A care plan, dated 5/26/12, for exhibition of distressed mood symptoms as evidenced by history of depression listed "AIMS testing as required or as needed...".</p> <p>Review of the record revealed that the facility failed to develop behavior monitoring sheets and an AIMS test was not completed on admission for the use of Abilify.</p> <p>E7 (LPN- medication nurse assigned to resident) confirmed during an interview on 6/5/12 that the facility should have initiated a behavior sheet for Alprazolam and Abilify for R144 on admission (5/25/12). E7 initiated one after the interview. E7</p>	F 329	<p>Resident R 144 remains in the center and has a behavior monitoring sheet and AIMS test in place. The resident was reviewed by the ICP team and the plan of care was reviewed and updated as necessary to reflect the resident's current level of care. Current residents on psychotropic medications have been reviewed to determine behavior monitoring sheets and AIMS tests are in place and current.</p> <p>In-servicing shall be completed on or before July 18, 2012 for licensed nursing staff on AIMS testing and Behavior Monitoring sheets.</p> <p>Audits shall be completed monthly for the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.</p> <p>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12
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F 329	<p>Continued From page 26</p> <p>also confirmed that an AIMS test should have been completed upon admission.</p> <p>2. Review of R146's MDS dated 3/13/12 revealed she was assessed as being severely cognitively impaired.</p> <p>R146 had a physician order dated 5/10/12 for Alprazolam 0.25 mg one by mouth twice a day for increased anxiety</p> <p>Review of R146's MAR revealed she was administered Alprazolam twice a day since 5/11/12.</p> <p>Review of the Behavior Monitoring Flow Record (BMFR) for the same period of time noted no symptoms of being jittery and nervous.</p> <p>An interview with E8 (RN unit manger) and E9 (LPN) on 6/5/12 at 10:20 AM confirmed the facility failed to develop a BMFR that document R146's behaviors demonstrating she was anxious that required the use of Alprazolam.</p>	F 329		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>	F 441		

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F 441	<p>Continued From page 27</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures it was determined that the facility failed to prevent the transmission of disease and infection to residents in the facility. The facility failed to ensure that staff disinfected the glucometer in between resident use. Findings include:</p> <p>During medication observation on 6/1/12 at approximately 4:25 PM, E10 (nurse) used the</p>	F 441	<p>Employee E10 has been educated on the proper cleaning of the glucometer. There have been no issues identified elsewhere in the facility.</p> <p>In-servicing shall be completed on or before July 18, 2012 for licensed nursing staff on disinfecting and cleaning of glucometer.</p> <p>Random audits shall be completed monthly over the next 90 days to determine compliance. This shall be the responsibility of the Infection Control Nurse/designee.</p> <p>The IC nurse shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	7/18/12
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F 441	<p>Continued From page 28</p> <p>glucometer to obtain blood from R246 and failed to disinfect the glucometer before use. After using the glucometer, E10 used the disinfectant wipe to clean only the test strip port area. An interview immediately after this observation revealed that it was E10's understanding that the wipe is used to clean the strip port area and not the entire glucometer.</p> <p>Review of the manufacturer's information for cleaning the monitor indicated to "do not try to clean the stirp port." Review of the facility's policy titled "9.16 Glucometer" indicated under "Procedure", "3. Disinfect meter before patient use."</p> <p>An interview with E26 (Staff Development Educator) on 6/2/12 at approximately 9 AM revealed that the entire glucometer must be cleaned including the strip port before resident use.</p>	F 441	<p>The call light systems for the areas identified have been repaired and are functioning properly. Rounds of the facility have been completed and no further issues were identified.</p>	7/18/12
F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations in the station I shower room on 6-6-12, it was determined that the facility failed to maintain a properly functioning call bell system. Findings include:</p> <p>1. None of the 5 pull stations for the call bell</p>	F 463	<p>In-servicing shall be held on or before July 18, 2012 for facility staff on notifying maintenance of malfunctioning calls lights.</p> <p>Random rounds shall be completed monthly by the maintenance department to determine compliance. This shall be the responsibility of the Director of Maintenance/designee.</p> <p>The Director of Maintenance shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</p>	

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F 463	Continued From page 29 system in the shower room activated the over-door, exterior light when the chord was pulled. The small light panel at the nurses station did activate as did the indicator light at the pull station.	F 463		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</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 observation, record review and interview it was determined that for one (R167) out of 51 sampled residents the facility failed to ensure the current physician's orders were accurately and completely transcribed to the medication administration record (MAR) to ensure a complete clinical record. Findings include:</p> <p>1. During a medication pass observation of R167 on 6/1/12 at 8:20 AM with E7 (LPN) it was noted that Digoxin 0.125 mg (heart medication) and Senna (laxative) two tablets were not</p>	F 514		

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F 514	<p>Continued From page 30 administered to the resident and were not documented on the June 2012 MAR as being ordered.</p> <p>a. Review of the clinical record documented Digoxin 0.125 mg daily was initialed on 4/22/12 with the admission orders and no discontinue order was found. The May MAR documented that the Digoxin was administered daily in the morning, This physician's order was not carried over to the June MAR.</p> <p>b. A physician's order was written on 5/23/12 for Senna two tablets to be increased from daily to twice a day. Review of the June 2012 MAR documented the Senna tablets to be administered in the evening only. The physician's change was not carried over to the June MAR.</p> <p>c. A physician's order for Miralax 17 gm daily was written on 5/23/12. The Miralax was not on the June MAR.</p> <p>An interveiw on 6/4/12 around 9 AM with E7 revealed that the discrepancies between the physician's orders and the June 2012 MAR were not picked up by nursing staff when initiating the June 2012 MARs. E7 was unsure why this happened.</p>	F 514	<p><b>Resident R 167 remains in the center and continues to receive medications ordered by the physician. Current resident's physician orders and MAR have been reviewed to determine proper transcription.</b></p> <p><b>In-servicing shall be completed for licensed nursing staff on medication encapsulation of orders on or before July 18, 2012.</b></p> <p><b>Audits shall be completed monthly for the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.</b></p> <p><b>The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.</b></p>	7/18/12	



**DELAWARE HEALTH  
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Division of Long Term Care  
Residents Protection

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

STATE SURVEY REPORT

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NAME OF FACILITY: Silver Lake Center Nursing Home

DATE SURVEY COMPLETED: June 7, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from May 30, 2012 through June 7, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 116. The Stage 2 sample totaled 51 residents</p>	<p>The facility provides the following Plan of Correction without admitting or denying the validity of the existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.</p>
3201	<p><b>Skilled and Intermediate Care Nursing Facilities</b></p>	<p><i>3201 - Skilled and Intermediate Care Nursing Facilities</i></p>
3201.1.0	<p>Scope</p>	<p>Cross-refer to CMS 2567-L survey report date completed 7/18/12, F241, F272, F279, F280, F309, F314, F329, F441, F463 and F514.</p>
3201.1.2	<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>	

Provider's Signature [Signature] Title Administrator Date 7/5/12



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STATE SURVEY REPORT

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NAME OF FACILITY: Silver Lake Center Nursing Home

DATE SURVEY COMPLETED: June 7, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Cross refer to the CMS 2567-L survey report date completed 6/7/12, F241, F272, F279, F280, F309, F314, F329, F441, F463, F514.</p>	