

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 156	<p>The sign was posted at the time survey. The receptionist will check daily to ensure the sign is posted.</p> <p>January 25, 2012</p>	1/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William James</i>	TITLE <i>N.H.A.</i>	(X6) DATE <i>12/1/11</i>
-----------------------------------------------------------------------------------------------	------------------------	-----------------------------

A 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.

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 156

Continued From page 1

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

F 156

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 156	<p>Continued From page 2</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that although the facility had the state agency survey results in the lobby, the facility failed to display a sign indicating where the survey results were located. Additionally, the Medicare and Medicaid phone numbers were not posted. Findings include:</p> <p>Observation of the facility lobby, hallways and</p>	F 156			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 156	Continued From page 3 common areas on 11/3/11 revealed the above listed information could not be found within the building.	F 156		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the</p>	F 225	<p>The employee's criminal record check has been completed. We have checked 100% of all employee files to ensure criminal record checks are complete. It is our policy that criminal record checks be completed in accordance with the requirements. No changes are needed to this policy. However, we have reinforced the policy with a new hire checklist that is completed by the Human Resource Department to ensure completion of all employee files. A random sample of new employee files will be chosen for review on a monthly basis to ensure all documents per requirements and per policies. Human Resources is responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 225	<p>Continued From page 4 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of employee records, policies and procedures, and staff interview, it was determined that the facility failed to adequately screen one (E7) of ten sampled employees for a criminal background check to ensure the staff had not been found guilty of abuse and neglect. E7 (Certified Nursing Assistant, CNA) lacked the criminal background checks per State and Federal regulations. Findings include:</p> <p>The facility's policy and procedure regarding Abuse, "Employee screening" stated, "a minimum of two reference checks ..., a criminal background check, adult and child abuse check and drug screening are required before an offer of employment is extended".</p> <p>Review of the facility employee documents revealed that one (E7) of ten staff, hired on 8/22/11, did not have the federal or state criminal background records on file. The adult abuse, child abuse and drug test screening were completed and in the file. On 11/2/11, an interview with E8 (Human Resource Manager)</p>	F 225		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707	
(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 225	Continued From page 5 revealed that she could not find the document.	F 225		
F 241 SS=E	<p>In an interview with E9 (State Agency Criminal Background Administrator) on 11/3/11, he stated there was no information for E7 in the database for this facility. E9 provided additional data on 11/8/11 that E7 was fingerprinted on 11/4/11.</p> <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 observation and interview, it was determined that the facility failed to ensure that care was provided in a manner and in an environment that maintains or enhances residents' dignity and respect in full recognition of their individuality. The facility failed to maintain R116's dignity while eating his breakfast in bed unclothed and in view from the doorway and failed to knock at 8 residents' rooms (R25, R85 R48, R113, R56, R54, R7, R93) and bathrooms before entering. Findings include:</p> <p>1. On 11/4/11, while the surveyor was walking along the 500 East Wing hallway, R116 was observed unclothed in bed in his room eating breakfast. E26 (CNA) left this resident's bed curtain opened (not drawn) and R116's door wide open in view of others..</p> <p>In an interview with E26 (CNA) on 11/4/11, he</p>	F 241	<p>R116 – The care plan has been updated to direct staff to close door when resident is eating in room and unclothed.</p> <p>R113, R56, R54, R7, R93, R25, R85, and R48: No plan of correction is needed for these residents. Please see our plan of correction below.</p> <p>It is our policy to promote care for residents that maintains dignity and respect. No changes are needed to this policy. However, we have reinforced this policy with education and increased supervision. An inservice will be held prior to compliance date for all staff to review this citation as well as our policies. We have begun conducting resident care audits in order to observe care and services being provided to residents, that includes an observation of staff entering rooms to ensure knocking and asking permission to enter as is the requirement. Director of Nursing (DON) is responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 241 Continued From page 6 stated that R16 always wants to eat breakfast in bed without any clothes on and/or cover. E26 (CNA) went back into R116's room and closed his door per surveyor's suggestion. R116 did not voice any complaints after the door was left closed.

2. On 10/28/11, E24 (Housekeeper) was distributing toiletries in resident rooms 206A (R113), 207A (R56), 207B (R54), 208A (R7), 208B (R93), 209A (R25), 209B (R85), and 210B (R48). The residents were in their rooms and E24 failed to knock at the entry doors and bathroom doors before entering.

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 record review, observation and interview, it was determined that the facility failed to ensure that one (R109) out of 34 sampled residents, received an ongoing program of activities designed to meet, in accordance with her comprehensive assessment, her interests and promote, mental, and psychosocial well-being. Findings include:

R109 was admitted to the facility with diagnoses of dementia Alzheimer's type, HTN (hypertension), CHF (congestive heart failure),

F 241

F 248

R109 – This resident's activity status and program has been reassessed and care plan interventions implemented. All residents who have little or no socialization will be identified and care plans reviewed to ensure appropriate interventions. Our activity program for socially isolated residents is being reviewed by our consultant staff and recommendations will be made and implemented by compliance date. A quality measure for activities has been established and will be reviewed monthly as part of our Quality Improvement (QI) Program. If the measure is not met, an evaluation of the entire program will be completed and an action plan implemented. The Activity Director is responsible.

January 25, 2012

1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 248	<p>Continued From page 7 hyperlipidemia, CVA (stroke), anxiety and depression (manic depression).</p> <p>According to the Minimum Data Set (MDS) assessment, dated 10/10/11, R109's cognition was impaired (BIMS score 05 out of 15), she had no behaviors present, and was totally dependent on staff for all activities of daily living (ADLs). Her very important daily activity preferences, according to her family, was listening to country music, cooking and going outside for fresh air when the weather is good.</p> <p>The facility initiated a care plan dated, 10/15/11 which stated, " Strengths, challenges, Preferences" "Because my dementia it is hard for me to verbalize my thoughts and feelings. I may enjoy individual and small group activities. I do not like being around large groups of people. I enjoy country music and cooking. I wish to spend my day concentrating on my therapy. I may also enjoy 1:1 interaction."</p> <p>The interventions/approaches included: "Staff will invite and offer escort to groups of interest. Activity staff will provide me with a monthly calendar" "Staff will be alert to signs that I need personal and/or emotional attention." "Staff will try to engage me in conversation at various times throughout the day."</p> <p>Review of R109's October 2011 documentation of her daily " Activity" log, revealed notations that she attends daily Physical Therapy (PT). However, R109 had been discharged from PT and OT(Occupational Therapy) on 10/15/11 and</p>	F 248			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 248	<p>Continued From page 8</p> <p>Speech Therapy on 10/24/11. Therefore, her source of personal/emotional attention and conversation was lessened. R109 will have to depend on the nursing and activity staff for the 1:1 interactions.</p> <p>Review of the October 2011 activity log revealed that on 11 out of 31 days, R109 had a visitor (husband) and had spent 1 day in the lounge area. In an interview with the husband on 11/4/11 @11:00 AM, he stated that he visits her everyday before lunch and returns in the evenings but they don't talk because she was always sleeping or had her eyes closed. Her activity log had no documented 1:1 interactions from the activity staff and there was no radio/CD's playing country music for stimulation which she enjoyed as per the care plan.</p> <p>R109 was observed daily in the AM and PM during the survey period and up until 11/4/11. R109 was observed lying in bed with her eyes closed/asleep. The husband was observed present but he just sat on a chair at the foot of the bed and watched her sleep.</p> <p>In an interview with E6 (LPN) on 11/4/11 at 10:30 AM, she stated that R109 could hear sounds and responded to touch even though her eyes were closed.</p> <p>The facility failed to provide R109's preferred activities, such as listening to country music on a radio, TV or CDs and listening to cooking shows.</p> <p>During an interview with E27 (Activity Director) on 11/4/11, she acknowledged the findings.</p>	F 248		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 253 SS=E	<p>Continued From page 9 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey and the environmental tour with the facility Operations/Maintenance Director (E9) and Maintenance Supervisor (E10) on 11/2/11, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include:</p> <p>1A. Unpainted, dirty or scratched walls and walls in disrepair were observed in resident rooms: 105, 106, 203, 205, 206, 207, 301, 310, 400, 403, 500, 600, outside room 403 and 500. Additionally on 11/4/11, the activity room wall in the 400 unit was observed with a missing baseboard.</p> <p>1B. Stained walls (appeared as liquid drips or spills and not cleanable) were observed outside rooms 207 and 301. Additionally on 11/2/11, the floor of the East wing biohazard floor was dirty (brown/black dirt) and the wall sink was dirty holding dirty water.</p> <p>In an interview with E9 on 11/2/11, he stated that they usually paint residents' rooms when it is agreeable with the resident. In an interview with R1 on 11/2/11 at 10:45 AM with E9 present, the resident stated he has been at the facility for a year and no one has asked him about doing any</p>	F 253	<p>All citations have been repaired or replaced. We have completed a review of the entire facility and made a list of needed repairs. These repairs will be made over the next year. We have implemented a new preventive maintenance and repair schedule as well as an environmental audit tool. Environmental audits will occur quarterly to identify issues and implement an action plan. In addition, there is a maintenance repair book on each wing that is checked daily, where staff can document issues. Maintenance will check this daily. Maintenance Director is responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12
---------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 253	<p>Continued From page 10 painting in his room.</p> <p>2. Encrusted dirt was observed around the edges of the bathroom floor in resident rooms or in resident rooms: 105, 106, 203, 205, 210, 301 and 600.</p> <p>3. An oxygen concentrator filter was observed with heavy dust in resident rooms 105 and 500 (R40 and R68).</p> <p>4. The caulking of one shower stall floor base in the 600 unit resident common shower room was observed black, dirty and in disrepair. Additionally on 11/2/11, the caulking around the base of the toilet in resident bathroom 600 was observed brown, stained and in disrepair.</p> <p>5. Dirt/debris or stained equipment was observed on the following: - A chair was observed dirty/stained in resident room 203A. - A tube feed stand had encrusted debris in room 500A. - The wheelchairs for residents in rooms 301, 304, and 501A were dirty. - A Hoyer lift platform located outside room 201 and in the 600 unit was dirty.</p> <p>6. The privacy curtain in rooms 301 and 304B were off the hooks.</p> <p>7. The toilet paper holder in room 203 was in disrepair. A thermostat dial was missing the cover from resident room 301.</p> <p>8. Observations of the West and East wing resident common shower rooms on 11/2/11 revealed chairs and equipment blocking access</p>	F 253		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 253 Continued From page 11 to the toilet area and the hand-sink. Residents and/or staff were unable to wash their hands or use the toilet. Additionally, soap bottles were observed stored in these shower rooms on top of the toilet area or on shower stalls handrails.

On 11/2/11, an interview with E9 and E10 confirmed these findings.

F 278
SS=D 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.

F 253

F 278

R97 – Dental consult has been procured for this resident and care plan interventions updated. All residents with dental concerns will be considered at risk related to this citation. We have identified those residents requiring needed services and will provide the service prior to compliance date. We will check MDS accuracy over the next quarter with each resident's quarterly assessment schedule and make modifications as needed.

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 278	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that MDS (Minimum Data Set) assessments for one (R97) out of 34 sampled residents failed to accurately reflect the resident's status. Findings include:</p> <p>Review of R97's admission nursing assessment form on 5/21/11 revealed that the resident had missing teeth, caries, and broken teeth.</p> <p>R97's admission MDS, dated 5/28/11 and quarterly MDS, dated 8/28/11 documented that there were no dental concerns for this resident.</p> <p>Observation on 10/31/11 at 9:48 AM revealed that R97 had missing teeth and decayed appearing, broken teeth with heavy tartar build-up.</p> <p>Review of the information with E3 (Registered Nurse Assessment Coordinator) on 11/4/11 at 2:15 PM confirmed R97's MDS was inaccurately coded for dental care. E3 stated that "broken teeth" should have been identified in the assessments.</p> <p>In an interview with R97 on 11/4/11 at 2:24 PM, he stated he needed dental care and wanted to see a dentist.</p>	F 278	<p>Assessment procedures are being reviewed with our MDS Coordinators to ensure procedures are followed for completion of the MDS that include interviews with residents, staff and families, as well as record reviews as per Resident Assessment Instrument Manual (RAI). This is being performed in collaboration with our outside consultant staff. Assessment procedures will be updated as needed and MDS Coordinators educated. Quarterly audits for MDS accuracy are performed by our consultant staff. Any ongoing coding issues will result in MDS modifications and an analysis of the problem in order to identify system or training issues. The DON is responsible for ensure appropriate actions are taken.</p> <p style="text-align: right;">January 25, 2012</p>	
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</p>	F 280		1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 280	<p>Continued From page 13 participate in planning care and treatment or changes in care and treatment.</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, observation and interview, it was determined that the facility failed to ensure that two (R109 and R85) out of 34 sampled residents' care plans were reviewed and revised as their status changed to meet their needs. Findings include:</p> <p>Cross-refer to F248 1a. R109's care plan, dated 10/15/11 and entitled "Strengths, challenges, Preferences Because my dementia it is hard for me to verbalize my thoughts and feelings. I may enjoy individual and small group activities. I do not like being around large groups of people. I enjoy country music and cooking. I wish to spend my day concentrating on my therapy. I may also enjoy 1:1 interaction"</p>	F 280	<p>R109 – This resident's activity status and program has been reassessed and care plan interventions implemented. In addition, the care plan related to skin interventions has been reviewed and updated. R85 – This resident's urinary status has been reassessed and care plan interventions updated in accordance with this assessment. All residents will be considered at risk related to this citation. We will review all residents' care plans over the next quarter with their quarterly assessment schedule. Prior to compliance date, we will review care plans related to activities, skin and urinary status to ensure appropriate updates and interventions. It is our policy to ensure resident care plans accurately reflect needs. No changes are needed to this policy. However, with the assistance of our consultant staff we will educate the Interdisciplinary Team (IDT) with regards to assessment and care planning and rules related to revision and update of the care plan. A clinical meeting is held Monday through Friday with the IDT and the DON. The purpose of this meeting is to review resident changes and review clinical record documentation including care plans. Identified issues with regards to care planning will be analyzed and action plans implemented. The DON and the IDT is responsible.</p>	
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

January 25, 2012

1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 280	<p>Continued From page 14</p> <p>This care plan's interventions/approaches included the following to help R109: Staff will invite and offer escort to groups of interest. Activity staff will provide me with a monthly calendar Staff will be alert to signs that I need personal and/or emotional attention. Staff will try to engage me in conversation at various times throughout the day.</p> <p>This care plan was not reviewed and revised by a team of qualified persons as the resident's status changed.</p> <p>The resident's preferred and/or very important activities were not incorporated into the approaches/interventions, such as listening to country music and some cooking shows on television and providing 1:1 interaction in order to meet her needs.</p> <p>In an interview with E27 (Activity Director) on 11/4/11, she confirmed this finding.</p> <p>1b. Cross-refer to F314 R109's care plan for the problem of "Skin Breakdown (Stage 1 -Sacral) potential for new breakdown related to impaired mobility and impaired cognition, dated 10/3/11 was not revised to include the details of R109's turning and positioning needs as recommended by the wound care nurse.</p> <p>E25 (RN) confirmed this finding on 11/4/11.</p> <p>2. Cross refer to F 315 R85's care plan, established on 5/16/11 and last</p>	F 280			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 280	Continued From page 15 reviewed on 8/16/11, on the problem of "Incontinence urinary, bowel r/t impaired mobility, diminished balance, ROM, unsteady gait, impaired vision as evidenced by involuntary passage of urine before reaching the toilet" was not revised. The facility failed to reassess the effectiveness of the interventions and failed to revise the interventions to include prompted voiding or a scheduled toileting program to meet the needs of this resident and prevent decline in bladder function.	F 280		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that one (R109) out of 34 sampled residents who had a pressure sore received the necessary care and services and failed to follow their system in place in a timely manner to promote healing of the existing pressure sore. R109 was admitted with a Stage 1 sacral</p>	F 314	R109 – The resident's care plan has been reviewed to ensure appropriate interventions to heal the current wound and prevent additional wounds from developing. The current wound has appropriate treatments and is being monitored and this monitoring is being documented weekly as per policies.	

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 314	<p>Continued From page 16</p> <p>pressure ulcer which developed into a non-healing, unstageable pressure ulcer 18 days after admission to the facility. The facility failed to have a system in place to communicate the recommendations of the wound care nurse for incorporation into the plan of care. Finding includes:</p> <p>R109 was admitted to the facility from the hospital with diagnoses of dementia Alzheimer's type, HTN (hypertension), CHF (congestive heart failure), hyperlipidemia, anxiety, CVA (cerebral vascular accident-stroke) and depression/manic depression.</p> <p>According to R109's Admission Minimum Data Set (MDS) assessment, dated 10/10/11, this resident had cognitive impairment and was totally dependent on staff for bed mobility and all activities of daily living (ADL). R109 was admitted to the facility with an indwelling foley catheter.</p> <p>An admission nurse's note, dated 10/3/11 stated, "...has redness at the bottom and around the groin..." A nurse's note, dated 10/5/11 stated, "...Dx. Stage 1 sacrum." The Stage 1 pressure ulcer was being treated with Barrier cream since admission.</p> <p>The facility initiated a care plan for R109, dated 10/3/11 for the problem "Skin Breakdown (Stage 1-sacral) potential for new breakdown related to impaired mobility and impaired cognition."</p> <p>The care plan approaches included "...4. Apply protective barrier or barrier lotion after incontinence as indicated-Barrier cream q shift...7. Inspect and chart skin integrity every day</p>	F 314	<p>All residents with wounds are at risk related to this citation. Please see our plan of correction below.</p> <p>We have initiated weekly wound rounds to be completed by the UM in collaboration with the charge nurses in order to assess and document all resident wounds. We have reviewed our documentation policies and no changes are needed at this time. All new wounds are documented on the 24-hour report and investigated in order to determine the cause and develop treatment/prevention plans. It is not our policy to generate an incident report for wounds identified on admission. However, a comprehensive resident assessment is completed to identify risk factors related to the wound in order to implement appropriate interventions. The UM and the entire team reviews the 24-hour report daily to ensure adequate treatments and notifications, as well as initial documentation on the wound sheets.</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 314	<p>Continued From page 17 with care and with weekly skin assessments."</p> <p>Review of the 10/11 CNA ADL flow sheets for daily skin checks revealed inconsistent documentation of inspection of the skin. The CNAs did not sign off on the 11-7AM, 7-3 PM & 3-11 PM shifts while providing care from 10/4/11 through 11/3/11.</p> <p>R109's 7-3 PM shift daily "Skilled Nursing Note" Nursing Assessment" documentation revealed the following: 10/4/11 through 10/18/11 - Skin Condition- ulcer Stage 1 sacrum 10/19/11 Skin condition - check marked as a "surgical wound" "Stage 2 on sacrum" by E18 (7-3 PM LPN). This daily documentation failed to include the size and current status such as drainage if present. There was no skin documentation sheet that can be found in the treatment sheet and/or that the Unit Manager was notified to re-assess the area for change in the wound's condition. 10/20/11 Skin condition - ulcer "unstageable on sacrum" assessed by E28 (LPN)</p> <p>A nurse's note, dated 10/20/11 @ 1200 stated, "...Stage 1 sacral area worsened and now DTI (deep tissue injury) measuring 2.0 x 4.0, surrounding tissue IAD (incontinence associated dermatitis). According to the 3rd Edition of "Quick Reference to Wound Care" a DTI (deep tissue injury) " is a purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear."</p> <p>In addition and according to the facility's Skin</p>	F 314	<p>The licensed nurse is responsible for prompt notification of the physician in order to obtain treatment orders that are then followed by the licensed staff. These policies have been reviewed with licensed staff prior to compliance date.</p> <p>Condition change audits, that include a review of the 24-hour report for wound identification and then an audit to ensure notification, treatment orders, and documentation per our policies are completed with each new wound identified by the UM. In addition, a weekly skin report is provided to the DON and the ADM that includes progress toward healing. The UM, DON and ADM are responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12	

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 314	<p>Continued From page 18</p> <p>Care policy/procedure, the Unit Manager or Treatment Nurse would assess the area initially and weekly thereafter using the weekly "Wound or Pressure Sore Identification and Progress Record." Initially on 10/3/11 (admission) R109's sacrum was assessed as a Stage 1 pressure sore measured as 3.0 x 3.0, no drainage and intact.</p> <p>10/6/11 reassessment indicated that the area was closed.</p> <p>10/16/11 the area of Stage 1 pressure sore measured 2.0 x 3.0, no drainage and intact. According to the Weekly "Wound or Pressure Sore Identification and Progress Record dated 10/20/11, the wound's status changed to non-stageable and measured L 4.0 x W 5.0 x D 0.1, no drainage, flat edges and intact.</p> <p>The facility's policy entitled "Skin Care" 2.3.1 stated "When a wound develops and is found either through skin checks...Nurse examines the wound, gets a treatment order from the physician, and completes a skin sheet....Completion of an incident report, an assessment investigation (usually performed by the Unit Manager) that assess how this happened, ...what care plan interventions now need to be implemented if any to prevent further problem and will be documented in the IR (incident report). However on 11/7/11 an incident report was requested from E2 (Director of Nursing) due to the change in wound status to "unstageable". E2 (DON) and E25 (RN, UM) failed to provide a copy of the incident report with the results of an assessment investigation related to the wound's change in status.</p> <p>In an interview with E6 (LPN) on 11/4/11 at</p>	F 314		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 314	<p>Continued From page 19</p> <p>approximately 10:30 AM, she stated that a wound care nurse from the hospital comes to the facility every Thursday and assesses R109's wound, measures the wound and makes treatment recommendations.</p> <p>The WCN (wound care nurse's) assessment on 10/27/11 documented that the wound size was L 3.5 x W 4.0 x 0.5 D (depth), non stageable, scant serous drainage, flat edges, wound bed with eschar 10% and 90% slough(a layer of dead tissue in a wound bed separated from the surrounding living tissue, delays healing and must be removed), periwound intact. The WCN documented her recommendations in the weekly sheets and in the "Report of Consultation" sheet dated 10/27/11. The WCN note in the "Report of Consultation sheet was written as follows: Pt. (patient) seen with nursing and PT. Sacral wound had declined. Recommend: (1) Discontinue barrier cream to sacrum (2) Santyl, adaptic, Cosmepore daily (3) position only on R & L (right and left) side except meals.</p> <p>On 11/3/11the wound was observed with E25 (RN, Unit manager). There was presence of black layer of scab/slough on top of the wound bed separated from surrounding living tissue.</p> <p>Review of R109's record revealed that the Wound Care Nurse's treatment recommendation was not followed. The daily Santyl, adaptic, Cosmepore was not initiated from 10/27/11 through 11/3/11 (x 7 days delay). In addition, included in the wound care nurse's recommendation was to "position only on R & L side except meals ". There was no documentation found in the nurse's</p>	F 314		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 314	<p>Continued From page 20</p> <p>note/physician's progress and or on the Report of Consultation sheet to indicate that the physician was aware of the plan of care recommended by the WCN. Additionally, the care plan and the CNAs care plan were not revised to communicate the turning and positioning needs of this resident as recommended by the wound care nurse. In an interview with E25 (RN,UM) on 11/4/11, at approximately 11:00 AM, she acknowledged these findings.</p> <p>R109 was observed on 11/3/11 at 10:30 AM and 2:00 PM in her room lying on her back. On 11/4/11 at 10:30 AM and 2:00 PM R109 was observed lying on her back.</p> <p>On 11/3/11 the WCN assessed R109's sacral wound and described the wound size; L 2.4, W 3.0, D 0.1 non stageable with scant serous drainage, 5% granulation and 95% slough, intact and recommended to continue the treatment of Santyl, adaptic, and cosmepore.</p> <p>Review of R109's Physician's order sheet (POS) revealed that on 11/4/11 the physician's order was obtained for the daily dressings of " Santyl daily after cleanse with NSS - start today", a 7 day delay.</p> <p>Additionally R109 was assessed as always incontinent of bowel. The facility's "Incontinence Management Program Policy" that included bowel incontinence "used for residents who are physically and/or mentally impaired and are kept dry solely through the efforts of the nursing staff" which calls for scheduled incontinence checks at regular intervals to keep Resident clean and dry and reduce risk of skin breakdown.</p>	F 314		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011	
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 314	<p>Continued From page 21</p> <p>Review of the 10/11 and 11/11 CNA ADL Tracking form showed that R109 was incontinent of bowel almost daily on the 7-3 PM and 3-11 shift although the number of episodes were not documented/shift as per form instructions.</p> <p>R309's care plan included the interventions:2. Keep skin clean and dry 3. Change incontinent pad ASAP (as soon as possible) after... bowel movement</p> <p>A Bowel...Elimination Pattern Evaluation to monitor and to determine R109's pattern of bowel movement every hour in all shift was found in R109's record which was initiated on 10/4/11 and continued until 10/5/11 (2 days), to identify the time and hour of bladder (R109 has an indwelling foley catheter) bowel incontinence to help prevent skin breakdown . However corresponding to the time of (every hour) the bowel incontinence occurred (to be mark as B) was not completed.</p> <p>In an interview with E2 (DON) on 11/7/11, she stated that the CNAs checked and changed resident's pads every 2 hours. However, CNAs ADL flow sheet failed to reflect that this was being done every 2 hours. As a result it also failed to reflect that her incontinent pad was changed ASAP (as soon as possible) after each bowel movement.</p> <p>On 11/4/11 at 10:30 AM, E6 (LPN) was getting ready to change R109's wound dressing when she discovered that R109 was incontinent of a significant amount of bowel movement. She was not informed that R109 needed her incontinent pad changed before she provided the treatment.</p>	F 314		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 314	Continued From page 22	F 314		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</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 one (R85) out of 34 sampled residents, who was incontinent of bladder received appropriate care and services to restore as much normal bladder function as possible. The facility failed to follow their system for managing urinary incontinence for R85 to prevent decline of bladder function. The facility failed to evaluate R85's bladder incontinence patterns by failure to complete a bladder schedule per facility's policy. R85's bladder function status declined from frequently incontinent to always incontinent. Findings include: The facility's "Incontinence Management Program</p>	F 315	<p>R85 – This resident's urinary status has been reassessed and the care plan developed to ensure the resident is kept clean and dry. Please also see our plan of correction below. All residents with incontinence will be considered at risk and will be reviewed to identify accurate needs related to care and services. We have reviewed and updated our incontinence program to ensure accurate assessment of resident needs. The program will include assessment, voiding / Bowel Movement trials, analysis of the trials, and care plan interventions that are congruent with the assessments. Licensed Nursing staff will be inserviced on the changes to the policies prior to compliance date. A checklist has been developed to ensure all routine admission assessments are completed and appropriate interventions based on resident needs implemented. This checklist is reviewed at the first care plan meeting. Subsequent care plan meetings will review all quarterly assessments and interventions to ensure interventions meet resident needs. DON, Unit Managers (UM), and Resident Assessment Coordinators (RNAC) are responsible.</p>	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011	
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 315	<p>Continued From page 23 Policy" was reviewed</p> <p>R85 was admitted with diagnoses of HTN, UTI, CVA, Alzheimer dementia, thyroid disorder, PVD, and hyperlipidemia. According to R85's admission Minimum Data Set (MDS) assessment, dated 5/19/11, her cognition status was severely impaired. R85 was totally dependent on two staff for toilet use and required extensive assistance of two staff in all of her activities of daily living (ADLs). Her bladder assessment indicated that she was frequently incontinent with an episode of continence (coded as 2).</p> <p>A care plan, initiated on 5/16/11 and last reviewed on 8/16/11, for the problem "Incontinence urinary, bowel r/t impaired mobility, diminished balance, ROM, unsteady gait, impaired vision" "as evidenced by involuntary passage of urine before reaching the toilet."</p> <p>The care plan goals and interventions were as follows: Resident will have no complications related to incontinence thru next review All needs will be met and anticipated by staff.</p> <p>Interventions included Check q 2 hrs and PRN, and assist with toileting as needed Provide bedpan/bedside commode, assist to bathroom as indicated Provide peri-care after each incontinent episode Assist resident to maintain dignity, privacy and independence Discuss with resident the triggers of stress incontinence such as coughing, sneezing, and</p>	F 315		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 315	<p>Continued From page 24 laughing Maintain pathway to toilet that is free of obstacles.</p> <p>The facility initiated on admission (5/13/11) a "Urinary Continence Evaluation" which indicated that R85 had absence of perception of a need to void and she was identified to have a functional type of incontinence, (that is, inability to toilet self due to cognitive and/or physical functioning)". The evaluation concluded that based on the type of (functional) incontinence, R85 was experiencing, the most appropriate type of intervention indicated which was only the absorbent products (use of pads), toileting devices, and external devices. This intervention did not follow the facility's definition of "Incontinence Management Program" to keep the physically and/or mentally impaired residents dry solely through the efforts of the nursing staff, to toilet as needed and all needs will be met and anticipated."</p> <p>According to the facility's policy and procedure for Incontinence Management, based on all information gathered, the resident who is noted to be "Dependent Continent", (which fits R85's functional incontinence) will be placed on the Habit training/Scheduled Voiding, that is, toileting of the resident will be on fixed schedule to keep resident dry.</p> <p>"For example, Day shift: Toilet after breakfast and after lunch; evening shift: Toilet after dinner and before bedtime; Night shift: Toilet on last continence rounds or upon resident awakening, briefs, pull ups and Specific times base on resident's individual voiding habits established by Bladder Schedule. Additionally, based on all</p>	F 315		
-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 315	<p>Continued From page 25</p> <p>information gathered, the resident who was noted to be Partially Continent will be placed on the Prompted Voiding Bladder retraining program. Resident will be prompted to use the toilet on a toileting schedule".</p> <p>R85's cognition had improved from severely impaired (code 3) on the admission assessment dated 5/13/11 to a cognition status of moderately impaired; cues/supervision required on the most current MDS assessment, dated 8/19/11. R85's ADL toilet use improved from totally dependent to extensive staff assistance. R85 was evaluated to have functional incontinence and needed the assistance of the nursing staff to anticipate her needs in toileting.</p> <p>However, review of R85's record lacked documentation to reflect that the facility reassessed her continency via Habit Training/Scheduled Voiding to gather data such as prompted voiding on a scheduled program to reflect that voiding and incontinent status of the resident was observed by staff.</p> <p>A nurse's note dated 9/8/11 timed 1200 stated, "MD in to visit with residents, does not wish to have resident back to bed after lunch and dinner; stated 'it's because of inactivity that she has a DVT (Deep Vein Thrombosis) ". This comment should have been considered to ambulate this resident through a scheduled prompted voiding.</p> <p>On 11/4/11, R85 was observed, alert and out of bed in a wheelchair and both legs elevated. R85's record lacked documented evidence that this resident was placed on a prompted voiding or habit training/scheduled voiding instead of the</p>	F 315			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 315	Continued From page 26 use of pads only. .R85's bladder function status declined from frequently incontinent with episode of continence (coded as 2) to always incontinent without episodes of continence (coded as 3). This was discussed with E1 (Administrator) and E2 (DON) on the informational meeting on 11/7/11.	F 315		
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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain the environment free from accidents hazards, as evidenced by an accessible and unlocked treatment cart, electrical outlets in disrepair, and an uncovered wall heater with exposed wires. Findings include: 1. Observation on 11/4/11 at 9:25 AM revealed an unlocked treatment cart on the East Wing with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E11 (Certified Nursing Assistant) on 11/4/11 at 9:35 AM, she confirmed the cart needed to be	F 323	All environmental findings have been corrected and staff inserviced on findings, roles and responsibilities. The environmental audits as described in F253 include safety measures such as those cited here and will be completed quarterly. In addition, staff is educated to ensure supervision on a daily basis in the normal course of their duties to comply with safety measures related to locked chemicals and to report needed in the maintenance communication log as described in F253. Maintenance director is responsible. January 25, 2012	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 323	Continued From page 27 locked. On 11/4/11 at 9:40 AM, interview with E12 (nurse) confirmed the cart needed to be locked and she proceeded to lock it. 2. Observations during the environmental tour with E9 (Operations Manager) and E10 (Maintenance Supervisor) on 11/2/11 at 9:59 AM revealed the following: A. a metal cover of an electrical outlet in the West Wing central bath was in disrepair. The metal cover was observed detached half-way from the wall. In an interview with E10 on 11/2/11, he stated that it appeared that the cover had been hit by equipment and the staff failed to alert them. The metal cover was immediately repaired by E10. B. a TV cable wire wall plate was in disrepair in room 201. C. the bottom of the wall heater in resident room 310 was missing a heater frame cover resulting in exposed wires. E9 and E10 on 11/2/11 confirmed this finding.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal	F 334		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 334	<p>Continued From page 28</p> <p>representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical</p>	F 334	<p>R70 – The pneumococcal vaccine has been provided to the resident. All residents will be considered at risk related to this citation. We will therefore review all resident files to ensure pneumococcal vaccines that are requested by the residents have been provided. Please also see our plan of correction below.</p> <p>It is the policy of this facility to offer vaccines at each admission and to document resident preferences. No changes are required to these policies. However, we have formalized the process to ensure the vaccines are given as requested by establishing a better communication and documentation system. Licensed staff has been educated on this process.</p> <p>Medical records (MR) personnel review new admission records to ensure vaccine documentation in accordance with resident wishes. In addition, a log has been established to document those residents that may require vaccine on a future date. The DON and MR are responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 334	<p>Continued From page 29 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of facility policies, and staff interview, it was determined that the facility failed to offer the pneumococcal vaccination to one (R70) out of five sampled residents. Findings include:</p> <p>The facility's policy entitled "Immunization Policy" stated "all residents (who give permission) will receive a pneumococcal vaccination on admission and every five years thereafter... During the admission process, it must be determined if and when the resident had the pneumococcal vaccination prior to admissionDocumentation of the vaccination every two years as indicated and ordered by the attending physician."</p> <p>R70 was initially admitted to the facility on 10/27/09. Review of the facility's pneumococcal immunization informed consent, dated 9/20/10 revealed that R70 gave the facility consent to administer the vaccine.</p> <p>Record review lacked evidence that the</p>	F 334		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707	
(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 334	Continued From page 30 pneumococcal vaccine was administered to R70. Interview with E13 (Certified Nursing Assistant/Unit Clerk) on 11/1/11 confirmed that R70 had not received the vaccine as she was unable to locate any additional information on this resident and had verified this with nursing staff. During an interview with E2 (Director of Nursing) on 11/4/11, she acknowledged that the facility failed to administer the pneumococcal vaccine to R70. The facility failed to administer the pneumococcal vaccine upon admission or during the resident stay at the facility as indicated in their procedures.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and interviews, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions in the kitchen. Findings include: 1. Review of two (2) out of two, dietary employee health records revealed that the facility lacked	F 371		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 31</p> <p>evidence that they had screened them for the five food-borne illnesses (Norovirus, Shigella and Hepatitis A, Salmonella and E coli) when they were first hired. The 2011 Delaware Food Code requires that newly hired employees be screened for the five food-borne illnesses before they start handling food. The screening of Food employees' health at the time of hire, would alert the facility if the new employee had certain food-borne illness that would prevent them from working with food.</p> <p>E20 and E21 were hired on 7/25/11 and 11/8/10, respectively. In an interview with E15 (Contract Temporary Food Service Director) on 10/28/11, she was not aware if they had screened the staff to determine if they had any of the above listed illnesses or were exposed to them when they were first hired.</p> <p>In an interview with E8 (Human Resource Manager) on 11/2/11, she revealed she did not have the health forms, or any indication of the staff screening for the five food-borne illnesses for any dietary staff.</p> <p>In an interview with E16 (Food Services Director) on 11/7/11, she revealed she thought the HR Director completed these screenings. The 2011 Delaware Food Code indicated that the Food service Director or Person in Charge in the kitchen was responsible for these screenings.</p> <p>2. Observations in the kitchen with E14 (Cook and Person-in-Charge) and E9 (Operations/Maintenance Director) on 10/28/11 at 8:10 AM revealed a box of non-pasteurized shell eggs stored inside the walk-in refrigerator. In an interview with E14 on 10/28/11, he stated they</p>	F 371	<p>The employees cited in the survey have had appropriate screening. In addition we have reviewed all dietary employee files to ensure screening in accordance with the requirements. Procedures have been developed to ensure cooking of unpasteurized eggs. It is our policy to ensure food temperatures on the steam table in accordance with the requirements. These policies have been reinforced with education and increased supervision to ensure logging of steam table temperatures at each meal. In addition, a new procedure has been developed to follow when temperatures are not in accordance with the requirements. Dietary staff has been educated on these policies. A new thermometer has been provided for the refrigerator cited. Temperatures are logged on the day and evening shift.</p> <p>Citations related to staff following infection control procedures (glove use and hand washing) and other environmental considerations (wet food pans, refuse barrels) have been addressed with staff education and increased supervision, as our policies address these issues in accordance with the requirements.</p>	

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 32</p> <p>offered the unpasteurized shelled eggs to a few residents to their preference, including fried and over-easy eggs. Omelets and scramble eggs were observed on the steam table at the time of the observation.</p> <p>On 10/28/11 at 8:30 AM, E14 stated that when he offered the unpasteurized shelled eggs cooked over easy to the residents, he always talked to his food service director (E16). E16 was not available for interview from 10/28/11 through 11/4/11. In an interview with E15 (Contract Temporary Food Service Director) on 10/28/11, she was unaware of what their procedures stated to do with the eggs as she could not locate the procedures and stated she had brought new procedures for the kitchen to be implemented shortly. In an interview with E15 on 11/2/11, she stated she switched from unpasteurized eggs to pasteurized shelled eggs. In an interview with E16 (Food Service Director) on 11/7/11, she denied that E14 had asked her about cooking the unpasteurized shell eggs fried over-easy.</p> <p>Review of the facility procedures on 11/7/11 revealed the facility lacked procedures indicating the temperature in which to cook the food. E16 acknowledged this finding.</p> <p>3. Observation of the kitchen steam table area on 10/28/11 at 11:30 AM revealed that the pureed fish was held at 110 degrees Fahrenheit (F). In an interview with E14 on 10/28/11, he asked the surveyor if the temperature was adequate to place in the steam table. The temperature was below the required 135 F per the 2011 Delaware Food Code.</p>	F 371	<p>A new kitchen environmental and staff supervision audit tool has been developed and implemented. Audits will be conducted weekly at various meals after inservicing and until 100% compliance is reached – audits will then move to a monthly basis at random meals. The Dietary Director is responsible.</p> <p>January 25, 2012</p>	1/25/12	

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 33</p> <p>Immediately after the interview with E14, the concern was brought to the attention of E15 (Temporary Food Service Director). E15 stated that the food should be reheated and requested the fish be reheated to the proper temperature. The puree fish was observed heated to 155 degrees Fahrenheit.</p> <p>Review of kitchen steam table temperature logs (from July 2011 through October 2011) revealed missing food temperature monitoring at the steam table although it was taken at two dining room tables. In an interview with E14 and E15 on 10/28/11, food was served from the kitchen steam table and E14 stated these numbers were not recorded. E15 confirmed this finding.</p> <p>4. Observation of the kitchen with E14 (Cook) on 10/28/11 at 8:15 AM revealed the inside of the walk-in refrigerator had no temperature gauge. Review of the temperature logs records for October 2011 revealed the staff did not monitor temperatures within this refrigerator on 10/27/11 and 10/28/11. On 10/28/11, an interview with E14 and E15 confirmed this finding.</p> <p>5. On 10/28/11, the food-contact surface area of two (2) stacks of ready to use food pans stored on the clean rack in the kitchen were observed dripping wet. E14 confirmed this finding.</p> <p>6. On 10/28/11 at 11:10 AM lunch observation of the kitchen steam table area was made. E22 was observed coughing into her ungloved hands. E22 proceeded to open the reach-in refrigerator door, removing food items from the refrigerator and then moved to the steam table to do food preparatory work for the lunch food trays. E22</p>	F 371		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 371	<p>Continued From page 34</p> <p>failed to wash her hands after coughing into them and before proceeding to any tasks. E22 was then observed a few minutes later placing clean gloves (still had not washed her hands) and proceeded to again work with food preparatory tasks. In an interview with E15 on 10/28/11, she confirmed E22 coughed but was not aware what she did afterwards, yet she requested E22 to wash her hands.</p> <p>7. An observation during the kitchen tour with E9 and E14 on 10/28/11 at 8:15 AM revealed two garbage/food refuse barrels (out of three) containing food refuse were uncovered. The lids were observed on the floor and the barrels not in use. The dietary staff were observed serving food for breakfast.</p> <p>On 10/28/11 at 11:10 PM, an observation of the kitchen area with E15 revealed one refuse barrel without a lid and another partially covered with a lid but garbage overflowing from the barrel. Both barrels with food refuse were uncovered. The facility failed to keep food refuse barrels tightly covered to prevent pest harborage.</p> <p>On 10/28/11 at 11:12 AM, E9 confirmed this finding. The facility failed to follow the 2011 Delaware Food Code requirements.</p>	F 371		
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in</p>	F 412		

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 412	<p>Continued From page 35</p> <p>making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review and interviews, it was determined that the facility failed to provide and/or obtain dental services for one (R97) out of 34 sampled residents. Findings include:</p> <p>Cross refer to F278 R97 was admitted to the facility on 5/21/11 with diagnoses that included anemia, coronary atherosclerosis, muscle weakness, and gait abnormality.</p> <p>Review of the admission nursing assessment, dated 5/21/11, revealed the nurse had assessed R97 with having missing and broken teeth, and caries. The physician's admission H&P (History and Physical), dated 5/23/11, stated under dental status "partially edentulous" (being without teeth).</p> <p>The admission and quarterly MDS assessments, dated 5/21/11 and 8/28/11 respectively, failed to code R97 under Section L-Oral/Dental Status as having "Obvious or likely cavity or broken teeth," despite the physician H&P and nursing admission assessment.</p> <p>Review of nursing, social services, and dietitian notes from 5/21/11 through 11/2/11 indicated that R97 had no dental concerns. There was no evidence that staff were aware of R97's missing and broken teeth, and caries. There was no</p>	F 412	<p>R97 – Dental consult has been procured for this resident and care plan interventions updated.</p> <p>All residents with dental concerns will be considered at risk related to this citation. We have identified those residents requiring needed services and will provide the service prior to compliance date.</p> <p>It is our policy to provide dental services as identified on admission and with the admission and quarterly assessments, as well as with condition changes. No changes are needed to this policy. However, we will educate the IDT regarding the findings of this survey and our policies prior to compliance date.</p> <p>The quarterly assessment review will be utilized to ensure all dental needs. In addition, our nutritional assessment policies will be utilized to identify potential dental problems as a cause of nutritional problems. Results of assessments will be analyzed to ensure our policies are being followed. UM, RNAC, Social Services (SS), and the DON are responsible.</p> <p style="text-align: right;">January 25, 2012</p>	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 412	Continued From page 36 evidence of any dental consults in the medical record. Observation of R97's on 10/28/11 revealed that he had a few bottom discolored and broken teeth and two missing front teeth. In an interview with R97 on 10/31/11 at 9:48 AM, he stated that he had gum problems and bleeding, had reported it to an aide and needed dental work. During an interview with E17 (nurse) on 11/4/11, she stated that resident's oral assessments were completed upon admission, quarterly, and when a resident or staff reported a problem. E17 acknowledged that staff failed to follow up on the dental oral assessment dated 5/21/11 with a dental consult for R97. In an interview with E3 (Registered Nurse Assessment Coordinator) on 11/4/11, she confirmed that the MDS assessments, dated 5/28/11 and 8/28/11, were inaccurately coded and that R97 should have seen a dentist. During an interview with E2 (DON) on 11/7/11, she acknowledged the concern and stated that they can get R97 to the dentist if he prefers. The facility failed to provide and/or obtain dental services to address R97's dental needs.	F 412			
F 441 SS=E	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.	F 441			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 441	<p>Continued From page 37</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to handle, store, and process linens to prevent the spread of infection in regards to storage of soiled linen and</p>	F 441	<p>Citations related to care and storage of facility linens were corrected at the time of survey. However, we have reinforced our storage policies with staff education and increased supervision.</p> <p>The environmental audits as described in F253 include linen storage such as those cited here and will be completed quarterly. Maintenance director is responsible.</p> <p>January 25, 2012</p>	1/25/12
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 38</p> <p>failed to ensure that protective equipment (gowns and masks) were free of contaminants for staff use. Findings include:</p> <ol style="list-style-type: none"> On 10/28/11 and 11/2/11 at 11:30 AM, and 11/3/11 at 9:30 AM, observations of the dryer area revealed the entry door was open. The clean room was not maintained under positive pressure as door opened onto a hallway that connected the dryer room to the kitchen and staff lounge. State regulations require the clean linen to be kept under positive pressure. Observations made throughout the survey and on 11/2/11 during the environmental tour with E9 (Operations/Maintenance Manager) and E10 (Maintenance Assistant Supervisor) revealed full soiled linen carts stored in the East and West wing hallways. The resident common shower rooms were also observed storing soiled linen which required they be vented and kept under negative pressure. A large soiled utility room was observed in the area and based on interview was not used for storing the carts full of soiled linen. In an interview with E9 on 11/2/11, he stated the soiled linen carts were kept in the hallways and showers and they would start storing soiled linen in the soiled utility room. <p>In an interview with E1 (Administrator) on 11/3/11, he revealed they should not be storing soiled linen in the hallways and shower rooms.</p> <ol style="list-style-type: none"> Observation of the laundry area on 11/2/11 at 11:23 AM with E9 (Operations/Maintenance Manager) and E19 (Laundry Staff) revealed an opened cabinet in the receiving soiled linen area of the laundry storing clean disposable gowns 	F 441			

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 441	Continued From page 39 and masks (and other supplies). The room stored carts of soiled bed and shower linens and was the room where laundry staff sorted the soiled linens for washing. The gowns were used by the staff to keep their clothing free of contaminants since they needed to go into the dryer room (clean area) to fold clean linens after having sorted the soiled linens for washing. This practice was unsanitary and had the potential for spreading infection. In an interview with E19 on 11/2/11, he revealed that he would move the cabinet.	F 441		
F 456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on an observation and staff interviews, it was determined that the facility failed to maintain a kitchen food warmer in a safe operating condition. Finding includes: On 10/28/11 at 11:15 AM, during a tour of the kitchen area, an observation of the warmer storing cooked food and used as a storage location until food was moved to the steam table revealed the external temperature gauge reading at a temperature of 95 degrees Fahrenheit. The internal temperature of the food warmer was measured using an electronic thermometer which revealed the temperature to be at 190 degrees Fahrenheit.</p>	F 456	<p>The external temperature gauge on the warmer was repaired.</p> <p>It is our policy to ensure food temperatures of the food warmer are in accordance with the requirements.</p> <p>The Dietary Director/ Designee will do daily temperature logs to ensure that all equipment is working properly.</p> <p>A new kitchen environmental audit tool has been developed and implemented. Audits will be conducted monthly on temperature logs of equipment.</p>	1/25/12

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2011
NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707		
(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 456	Continued From page 40 In an interview with E14 (Cook) on 10/28/11, he stated the temperature of the external gauge should be reading the temperature inside the warmer. In an interview E15 (Contract Temporary Food Service Director) on 10/28/11, she revealed she would contact maintenance staff as the internal and external temperature readings should be the same.	F 456			
F 520 SS=E	On 11/7/11, in an interview with E16 (Food Service Director), she revealed she would look into this and confirmed this finding. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	A physician, our Medical Director, has been informed of our requirements and the requirements at F520 and will be present at all meetings. We will arrange meetings so as to coincide with the Medical Director's schedule. Meetings held that do not have the Physician's attendance will be repeated to ensure ongoing communication and action plans related to facility identified issues. January 25, 2012	1/25/12	

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

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2011
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ST. FRANCIS CARE/BRACKENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707
--------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 520	<p>Continued From page 41 a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview, it was determined that the facility failed to meet the requirements for the number of Quality Assessment (QA) committee members to be present for quarterly meetings which included the Director of Nursing (DON), a physician and at least three other facility staff members. Findings include:</p> <p>Review of the facility QA quarterly meeting sign in sheets revealed that a physician was not in attendance at the 4/13/11 and 10/19/11 meetings.</p> <p>Interview with E1 (Administrator) on 11/7/11 revealed that the facility began to have QA meetings on a monthly basis in September, 2011. However, review of the 9/27/11 QA meeting sign in sheet also lacked evidence of physician participation. E1 acknowledged the findings.</p>	F 520		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--



**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 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

3201 3201.1.0 3201.1.2	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from October 28, 2011 through November 7, 2011. 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 79. The Stage 2 sample totaled 34 residents.</p> <p>Regulations for 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 refer to the CMS 2567-L survey report date completed 11/7/11, F156,</p>	<p>3201.1.2 Please refer to our plan of corrections at F156, F225, F241, F248, F253, F278, F280, F314, F315, F323, F334, F412, F441, F456, and F520. 3201.7.5 Please refer to F371</p> <p>January 25, 2012</p>
------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Provider's Signature William J. ... Title N.H.A. Date 12/2/11



**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 2 of 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

3201.7.5	<p>F225, F241, F248, F253, F278, F280, F314, F315, F323, F334, F412, F441, F456, and F520.</p> <p>Kitchen and Food Storage</p> <p>Areas. Facilities shall comply with the 2011 Delaware Food Codes.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-201.11, 2-301.14, 3-501.16, 3-801.11, 4-204.112, 4-901.11, 4-903.11 and 5-501.113 of the State of Delaware Food Codes. Findings include:</p> <p>2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.</p> <p>(A) The permit holder shall require food employees and conditional employees to report to the person in charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or conditional employee shall report the information in a manner that allows the person in charge to reduce the risk of food-borne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the food employee or conditional employee: reportable symptoms (1) Has any of the following symptoms:</p> <p>(a) Vomiting,</p> <p>(b) Diarrhea,</p>	
----------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 3 of 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

(c) Jaundice,
(d) Sore throat with fever, or
(e) A lesion containing pus such as a boil or infected wound that is open or draining and is:
(i) On the hands or wrists, unless an impermeable cover such as a finger cot or stall protects the lesion and a single-use glove is worn over the impermeable cover,
(ii) On exposed portions of the arms, unless the lesion is protected by an impermeable cover, r
(iii) On other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; reportable diagnosis
(2) Has an illness diagnosed by a health practitioner due to:
(a) Norovirus,
(b) Hepatitis A virus,
(c) Shigella spp.,
(d) Enterohemorrhagic or Shiga toxin-producing Escherichia Coli, or
(e) Salmonella Typhi; reportable past illness
(3) Had a previous illness, diagnosed by a health practitioner, within the past 3 months due to Salmonella Typhi, without having received antibiotic therapy, as determined by a health practitioner; reportable history of exposure
(4) Has been exposed to, or is the suspected source of, a confirmed disease outbreak, because the food employee or conditional employee consumed or prepared food implicated in the outbreak, or consumed food at an event prepared by a person who is infected or ill with:
(a) Norovirus within the past 48 hours of the last exposure,
(b) Enterohemorrhagic or Shiga toxin-



**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 4 of 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

producing *Escherichia Coli*, or *Shigella* spp. within the past 3 days of the last exposure,
 (c) *Salmonella Typhi* within the past 14 days of the last exposure, or
 (d) *Hepatitis A virus* within the past 30 days of the last exposure; or
 Reportable history of exposure
 (5) Has been exposed by attending or working in a setting where there is a confirmed disease outbreak, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a confirmed disease outbreak.
 (E) A food employee or conditional employee shall report to the person in charge the information as specified under ¶ (A) of this section. Pf responsibility of food employees to comply
 (F) A food employee shall:
 (1) Comply with an exclusion as specified under
 ¶¶ 2-201.12(A) - (C) and Subparagraphs 2-201.12(D)(1),(E)(1), (F)(1), or (G)(1) and with the provisions specified under ¶¶ 2-201.13(A) - (G); P or
 (2) Comply with a restriction as specified under Subparagraphs 2-201.12(D)(2), (E)(2), (F)(2), (G)(2), or ¶¶ 2-201.12 (H) or (I) and comply with the provisions specified under ¶¶ 2-201.13(D) - (I). P

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed, 11/7/11, F371, example 1.

2-301.14 When to Wash.



**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 5 of 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

	<p>Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single-use articles and:</p> <ul style="list-style-type: none"> (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling service animals or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled equipment or utensils; soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands. <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/7/11, F371, example 6.</p> <p>3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding.</p> <p>(A) Except during preparation, cooking, or cooling, or when time is used as the</p>	
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 6 of 8

JAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food) shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130oF) or above;</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/7//11, F371, example 3.</p> <p>3-801.11 Pasteurized Foods, Prohibited Reservice, and Prohibited Food.</p> <p>In a Food Establishment that serves a Highly Susceptible population:</p> <p>(B) Pasteurized shell eggs or pasteurized liquid, frozen, or dry eggs or egg products shall be substituted for raw shell eggs.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/7/11, F371, example 2.</p> <p>4-204.112 Temperature Measuring Devices.</p> <p>(A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be</p>	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 7 of 8

NAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.

(B) Except as specified in ¶ (C) of this section, cold or hot holding equipment used for potentially hazardous food (time/temperature control for safety food) shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.

This requirement was not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 11/7/11, F371, Example 4.

4-901.11 Equipment and Utensils, Air-Drying Required.

After cleaning and sanitizing, equipment and utensils:

(A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and

4-903.11 Equipment, Utensils, Linens, and Single-

Service and Single-Use Articles.

(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:



**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 8 of 8

JAME OF FACILITY: St. Francis Care Center at Brackenville

DATE SURVEY COMPLETED: November 7, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	----------------------------------------------------	--------------------------------------------------------------------------------------------------

	<p>(1) In a self-draining position that allows air drying; and</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/7/11, F371, Example 5.</p> <p>5-501.113 Covering Receptacles.</p> <p>Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered:</p> <p>(A) Inside the food establishment if the receptacles and units:</p> <p>(1) Contain food residue and are not in continuous use; or</p> <p>(2) After they are filled;</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 11/7/11, F371, example 7.</p>	
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--