

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

PRINTED: 06/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONEGATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4031 KENNETT PIKE GREENVILLE, DE 19807</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from May 19, 2015 through May 27, 2015. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 39. The Stage 2 survey sample size was 23.</p> <p>Abbreviations used in this 2567 are as follows:                      NHA - Nursing Home Administrator;                      DON - Director of Nursing;                      ADON - Assistant Director of Nursing;                      RN - Registered Nurse;                      LPN - Licensed Practical Nurse;                      CNA - Certified Nurse's Aide;                      MDS - Minimum Data Set (standardized assessment forms used in nursing homes);                      Incontinent - loss of control of bladder and/or bowel function;                      Cognition-process of memory, learning and thinking;                      Continent- control of bladder and/or bowel function;                      Occasional incontinence - less than 7 episodes of incontinence during a 7 day look back period;                      Frequently incontinent - 7 or more episodes of incontinence, but at least one episode of continent voiding, during a 7 day look back period;                      Voiding diary-record of the times a resident voids;                      Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;                      Nocturia - condition where a person wakes up during the night to urinate;                      Lasix - medication used to remove excess fluid from the body;</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Kim M Carr Administrator June 29, 2015*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000			
F 225 SS=D	<p>s/sx - signs and symptoms; UTI - urinary tract infection (infection in any part of the urinary system).</p> <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 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</p>	F 225	<p>The incident reports for R8 were reviewed by DON and discussed with staff. There was not believed to be any evidence of abuse or neglect with the identified incidents. R8 has care plans in place for bruising easily, r/t aspirin and Plavix and being resistive to care. A resident on such medications is at increased risk for bruising easily.</p> <p>Incident reports and weekly skin checks will be reviewed for all residents. Any incident of unknown origin and/or weekly skin assessment that indicates bruising will be reviewed and determine that proper reporting and investigating is initiated.</p> <p>An in-service for all staff will be conducted to review the facility policy on abuse, neglect and mistreatment. This in-service will also continue to be conducted annually. Supervisors will be in-serviced on proper reporting procedures and investigation process.</p> <p>All incidents will be reviewed weekly to ensure appropriate implementation of reporting and investigating. The DON/designee will be complete this review.</p> <p>Incident reports will be audited weekly for appropriate reporting and investigating by DON/designee. This audit will be reported through QAPI until 100% compliance is achieved.</p>	Completion: July 31, 2015 and ongoing	

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F 225	<p>Continued From page 2</p> <p>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 record review, interview and review of facility documents, it was determined that the facility failed to immediately report and thoroughly investigate injuries of unknown source (some of the bruises were located in an area not generally vulnerable to trauma) that had the potential for abuse for one (R8) out of 23 Stage 2 sampled residents. Findings Include:</p> <p>The facility's policy "...Health Center Nursing Policy and Procedure Manual - Subject: Reporting Unexplained Incidents, Mistreatment, Neglect, Abuse and Misappropriation of Property", last updated February 2009 stated, "...injury from an incident on (sic.) unknown source in which the initial investigation or evaluation concludes that there is a reasonable suspicion that the injury was caused by abuse, neglect, or mistreatment...".</p> <p>Review of R8's Weekly Skin Assessments revealed as follows new areas of bruising: -On 12/11/14 - left upper chest near breast 2 small bruises; -On 1/8/15 - small bruises on left and right breasts ...small bruise to right outer thigh ...; -On 1/18/15 - under left breast; -On 2/5/15 - ...Bruising to left wrist ...Bruising to left inner and outer thigh; -On 3/12/15 - top of left breast; -On 4/9/15 - small bruise to right chin; -On 4/30/15 - bruise to right upper arm.</p>	F 225			

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F 225	Continued From page 3  Review of facility documents revealed a lack of evidence that incident reports were completed for the following dates: 12/11/14; 1/8/15; 1/16/15; 2/5/15; 3/12/15; and 4/30/15. Facility documents also lacked evidence that any investigation had occurred for any date listed above.  Review of the Nurse Notes and Incident Notes revealed the following: -On 1/3/15 at 11:51 PM, "Family brought to my attention resident's upper and lower left eyelids swollen. Also, upper left eyelid noted to be bruised...Resident could not explain what happened."  -On 1/22/15 at 4:49 PM, "Resident noted with multiple bruise (sic.) to bilateral arms and bilateral breasts (near armpits) and left abdomen...Unable to verbalize appropriately on how the bruises occurred...";  -On 3/5/15 at 5:08 PM, "... resident noted with multiple bruises. Resident noted with bruising to left upper inner arm. Bruise to right breast. Bruise to right abdomen. Bruise to right axillary area. Bruise to right thigh. Resident not able to verbalize appropriately how the bruises occurred...";  -On 4/4/15 at 1:05 AM, "... bruise found on resident's right arm (above elbow)...says she does not know how bruise occurred and was unaware of it's existence...";  -On 4/9/15 at 11:18 AM, "... noted a small bruise on residents (sic.) right side of jaw. Resident unaware of how it occurred...";	F 225			

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F 225	Continued From page 4 -On 4/30/15 at 10:55 PM, "... Resident noted with a new bruise to right upper arm. Resident unable to verbalize appropriately how bruise occurred...";  Review of facility documents revealed a lack of evidence that incident reports were completed for the following dates: 1/3/15 and 4/30/15. Facility documents also lacked evidence that any investigation had occurred for any date listed above.  Although the facility did an incident report for some of the injuries of unknown source, not all of them, they failed to recognize these injuries as a potential for abuse, failed to investigate all of the injuries of unknown source listed above and failed to immediately report them to the State Agency.  In an interview on 5/26/15 at 3:10 PM with E2 (DON), she stated that she expected to see an incident report for each newly identified bruise.  On 5/27/15 at 9:32 AM, E2 confirmed the facility failed to complete a thorough investigation for all of the above incidents that had potential for abuse.  The facility failed to report and thoroughly investigate injuries of unknown source for a resident who could not explain the presence of the injuries.  Findings were reviewed on 5/27/15 at approximately 10:50 AM with E1 (NHA) and E2.	F 225		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically	F 272		

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F 272	Continued From page 5 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditlons; Activity pursuit; Medicatlons; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT Is not met as evidenced by:	F 272	A voiding diary was initiated on 5/27/15 for R17.  All new admissions who are incontinent or exhibit incontinence will have a 3 day voiding dairy initiated to determine voiding patterns.  A review of the policy for incontinence will be conducted and staff will be in-serviced on the procedure of initiating a voiding diary on admission.  All new admission records will be reviewed by DON/designee to ensure voiding diary was initiated on admission.	Completion: July 31, 2015 and ongoing

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F 272	<p>Continued From page 6</p> <p>Cross refer to F315</p> <p>Based on clinical record review, interview and review of facility documentation, it was determined that for one (R17) out of 23 Stage 2 sampled residents, the facility failed to comprehensively assess R17's urinary incontinence upon admission to the facility. Findings include:</p> <p>The facility's policy entitled "Urinary Continence and Incontinence - Assessment and Management", last revised in October 2010, stated, "The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence ... As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include: a. Voiding patterns ...".</p> <p>1/26/15 - The admission nursing assessment, under the urinary section, identified R17 as only having a non-distended bladder.</p> <p>2/1/15 - The admission MDS assessment revealed that R17 was occasionally incontinent of urine.</p> <p>Review of R17's clinical record revealed an Admission Checklist to be used for all admissions, which stated, "... 1. Complete admission assessment, to include pain, and start the voiding diary ...". R17's clinical record lacked evidence of a 3-day voiding diary.</p> <p>5/22/15 at 2:56 PM - In an interview, E3 (LPN) stated that the facility used to do 3-day voiding diaries and was not sure why they stopped doing them. E3 also stated that the admitting nurse would initiate the 3-day voiding diary. E3</p>	F 272			

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F 272	Continued From page 7 confirmed that they did not have a 3-day voiding diary from when R17 was admitted.	F 272		
F 280 SS=D	<p>The facility failed to comprehensively assess R17's urinary incontinence upon admission. Findings were reviewed with E2 (DON) on 5/26/15 at 2:05 PM.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <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: Cross refer to F315 Based on clinical record review, interview and review of facility documentation, it was determined that for one (R17) out of 23 Stage 2</p>	F 280	<p>Resident 17 care plan was reviewed since voiding diary was initiated. In an attempt to go paperless and adopt an electronic health record, we realized too late, that the voiding diary was not a part of the new EHR. As of the time of this survey the voiding diary is again included as a part of the admission process. The admission checklist will be reviewed for completion by the DN or her designee in order to assure that all admission information is complete for all new admissions.</p> <p>All incontinent residents will have care plans reviewed to determine they are updated and have appropriate interventions.</p> <p>A weekly team meeting will take place to review residents care plans, MDS data and assessments. (SEE ATTACHED A) The purpose of the review is to ensure completion of assessments, review MDS look back and care plans are up to date with appropriate documentation and interventions.</p> <p>Compliance with resident team meeting will be reported through QAPI. This will be ongoing. As we humans who provide care do make mistakes, and since perfection is the desired outcome, this will be an ongoing process.</p> <p>The DON/designee will be responsible for the compliance with this review.</p>	Completion: July 31, 2015 and ongoing.

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F 280	Continued From page 8 sampled residents, the facility failed to review and revise the urinary incontinence care plan when R17's incontinence changed from occasional to frequent. Findings include:  The facility's policy entitled Care Plans - Comprehensive, last revised September 2010, stated, "... 8. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change ...".  2/1/15 - The admission MDS revealed that R17 was occasionally incontinent of urine.  2/2/15 - R17 was care planned for occasional bladder incontinence.  5/3/15 - The quarterly MDS stated that R17 was frequently incontinent of urine, which was a decline in urinary continence from his admission MDS.  5/28/15 at 2:05 PM - In an interview, E2 (DON) confirmed that R17's care plan was not revised. The facility failed to review and revise R17's care plan for urinary incontinence after the quarterly MDS noted a decline in continence.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

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F 315	<p>Continued From page 9</p> <p>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 clinical record review, interviews and review of facility documentation, it was determined that for one (R17) out of 23 Stage 2 sampled residents, the facility failed to recognize the decline in R17's urinary continence and also failed to accurately assess, re-assess, monitor, review his incontinence episodes and implement approaches to manage his urinary incontinence and to restore as much normal bladder function as possible. Findings include:</p> <p>The facility's policy entitled "Urinary Continence and Incontinence - Assessment and Management", last revised in October 2010, stated, "The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence ... As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include: a. Voiding patterns ...".</p> <p>1/26/15 - R17 was admitted to the facility with diagnoses including dementia.</p> <p>1/26/15 - The admission nursing assessment lacked evidence of R17's urinary history and status.</p> <p>Review of R17's clinical record revealed an Admission Checklist to be used for all admissions, which stated, "... 1. Complete admission assessment, to include pain, and start</p>	F 315	<p>A voiding diary was initiated on 5/27/15 for R17. A voiding diary is not a part of the new EHR. In our effort to go paperless we discovered that that diary was not included in the assessments. Voiding diaries will be initiated on admission for those residents who are incontinent or exhibit signs of incontinence. An admission checklist is completed on all new admissions. These completed checklists will now be reviewed by the DN or her designee to assure that all items are addressed.</p> <p>All new admissions who are incontinent or exhibit incontinence will have a 3 day voiding dairy initiated to determine voiding patterns.</p> <p>A review of the policy for incontinence will be conducted and staff will be in-serviced on the procedure of initiating a voiding diary on admission.</p> <p>Weekly team meetings will be conducted to review residents assessments, care plan, and MDS look-back. The purpose of this meeting will be to determine completion of assessments, MDS documentation and appropriate care plan interventions.</p> <p>All new admission records will be reviewed by DON/designee to ensure voiding dairy was initiated on admission, along with the weekly meeting. This will be reported through QAPI until 100% compliance is achieved.</p>	Completion: July 31, 2015 and ongoing

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F 315	<p>Continued From page 10 the voiding diary ...".</p> <p>1/26/15 - The facility's form entitled Bowel and Bladder Program Screener stated that R17 always voided appropriately without incontinence, required the assistance of 1 person to assist with toileting, was always aware of the need to toilet and was a good candidate for urinary retraining.</p> <p>1/27/15 - The physician's admission history and physical revealed that R17 had nocturia.</p> <p>2/1/15 - The admission MDS assessment revealed that R17 was moderately cognitively impaired, needed limited assistance of 1 staff person for toileting, was occasionally incontinent of urine and not on a toileting trial. R17's clinical record lacked evidence of a 3-day voiding diary and implementation of a toileting program.</p> <p>2/2/15 - R17 was care planned for occasional urinary incontinence related to confusion, impaired mobility and the use/side effects of Lasix with interventions that included: "encourage fluids during the day to promote prompted voiding responses, ensure the resident has (sic) unobstructed path to the bathroom, monitor/document for s/sx UTI ...; and resident recognizes urge to void. will call when he needs to use the restroom".</p> <p>Review of the CNA bladder elimination documentation by month revealed the following:</p> <p>January 26-31, 2015 - incontinent 3 times out of 19 opportunities or 16%.</p> <p>February 2015 - incontinent 27 times out of 93 opportunities or 29%.</p>	F 315			

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PRINTED: 06/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONEGATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4031 KENNETT PIKE GREENVILLE, DE 19807</b>	
(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 11</p> <p>March 2015 - incontinent 24 times out of 134 opportunities or 18%.</p> <p>April 2015 - incontinent 29 times out of 130 opportunities or 22%.</p> <p>May 1 - 26, 2015 - incontinent 31 times out of 101 opportunities or 31%.</p> <p>4/27/15 - The Bowel and Bladder Program Screener stated that R17 would not always void appropriately without incontinence, required the assistance of 1 person to assist with toileting, was forgetful but followed commands, was usually aware of the need to toilet and was a good candidate for urinary retraining.</p> <p>5/3/15 - The quarterly MDS revealed that R17 was severely cognitively impaired, needed limited assistance of 1 staff person for toileting, was frequently incontinent of urine and not on a toileting trial.</p> <p>Despite changes noted both in the 4/27/15 screening form and the 5/3/15 MDS, the facility failed to recognize a decline in urinary continence and failed to implement new interventions in an attempt to manage R17's urinary incontinence.</p> <p>R17's clinical record lacked evidence of a 3-day voiding diary when his incontinence increased from occasional to frequent as noted in the 5/3/15 quarterly MDS.</p> <p>5/22/15 at 10:57 AM - In an interview, E4 (CNA) stated that R17 was never on a toileting program.</p> <p>5/22/15 at 2:56 PM - In an interview, E3 (LPN)</p>	F 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>STONEGATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4031 KENNETT PIKE GREENVILLE, DE 19807</b>		
(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 12</p> <p>stated that the facility used to do 3-day voiding diaries and was not sure why they stopped doing them. E3 also stated that the admitting nurse would initiate the 3-day voiding diary. E3 confirmed that they do not have 3-day voiding diaries from R17's admission and after the quarterly MDS which noted a change in urinary incontinent from occasional to frequent.</p> <p>5/26/15 at 2:47 PM - In an interview, E2 (DON) stated that the facility was initiating a 3-day voiding diary that evening for R17.</p> <p>The facility failed to recognize the decline in urinary continence and also failed to accurately assess, re-assess, monitor, review R17's incontinence episodes and revise approaches to manage R17's urinary incontinence and to restore as much normal bladder function as possible. Findings were reviewed with E2 on 5/26/15 at 2:05 PM.</p>	F 315			



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3 Mill Road, Suite 308  
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(302) 577-6661

**STATE SURVEY REPORT**

**NAME OF FACILITY: Stonegates**

**DATE SURVEY COMPLETED: May 27, 2015**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey was conducted at this facility from May 19, 2015 through May 27, 2015. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 39. The Stage 2 survey sample size was 23.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p>		
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Provider's Signature Kevin M Carr Title Administrator Date 4/29/15



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	<p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed May 27, 2015, F225, F272, F280 and F315.</p>	<p>225 The incident reports for R8 were reviewed by DON and discussed with staff. There was not believed to be any evidence of abuse or neglect with the identified incidents. R8 has care plans in place for bruising easily, r/t aspirin and Plavix and being resistive to care. A resident on such medications is at increased risk for bruising easily.</p> <p>Incident reports and weekly skin checks will be reviewed for all residents. Any incident of unknown origin and/or weekly skin assessment that indicates bruising will be reviewed and determine that proper reporting and investigating is initiated.</p> <p>An in-service for all staff will be conducted to review the facility policy on abuse, neglect and mistreatment. This in-service will also continue to be conducted annually. Supervisors will be in-serviced on proper reporting procedures and investigation process.</p> <p>All incidents will be reviewed weekly to ensure appropriate implementation of reporting and investigating. The DON/designee will be complete this review.</p> <p>Incident reports will be audited weekly for appropriate reporting and investigating by DON/designee. This audit will be reported through QAPI until 100% compliance is achieved.</p>	<p>Completion: July 31, 2015 and ongoing</p>
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Provider's Signature Kumorn Carr Title Administrator Date 6/29/15



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	<p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed May 27, 2015, F225, F272, F280 and F315.</p>	<p>272 A voiding diary was initiated on 5/27/15 for R17.</p> <p>All new admissions who are incontinent or exhibit incontinence will have a 3 day voiding diary initiated to determine voiding patterns.</p> <p>A review of the policy for incontinence will be conducted and staff will be in-serviced on the procedure of initiating a voiding diary on admission.</p> <p>All new admission records will be reviewed by DON/designee to ensure voiding diary was initiated on admission.</p>	<p>Completion: July 31, 2015 and ongoing</p>
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Provider's Signature Kim M Carr Title Administrator Date 6/29/15



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	<p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed May 27, 2015, F225, F272, F280 and F315.</p>	<p>280 Resident 17 care plan was reviewed since voiding diary was initiated. In an attempt to go paperless and adopt an electronic health record, we realized too late, that the voiding diary was not a part of the new EHR. As of the time of this survey the voiding diary is again included as a part of the admission process. The admission checklist will be reviewed for completion by the DN or her designee in order to assure that all admission information is complete for all new admissions.</p> <p>All incontinent residents will have care plans reviewed to determine they are updated and have appropriate interventions.</p> <p>A weekly team meeting will take place to review residents care plans, MDS data and assessments. (SEE ATTACHED A) The purpose of the review is to ensure completion of assessments, review MDS look back and care plans are up to date with appropriate documentation and interventions.</p> <p>Compliance with resident team meeting will be reported through QAPI. This will be ongoing. As we humans who provide care do make mistakes, and since perfection is the desired outcome, this will be an ongoing process.</p> <p>The DON/designee will be responsible for the compliance with this review.</p>	<p>Completion: July 31, 2015 and ongoing.</p>

Provider's Signature Karin M. Carr Title Administrator Date 6/29/15



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	<p><b>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 27, 2015, F225, F272, F280 and F315.</b></p>	<p>315 A voiding diary was initiated on 5/27/15 for R17. A voiding diary is not a part of the new EHR. In our effort to go paperless we discovered that that diary was not included in the assessments. Voiding diaries will be initiated on admission for those residents who are incontinent or exhibit signs of incontinence. An admission checklist is completed on all new admissions. These completed checklists will now be reviewed by the DN or her designee to assure that all items are addressed.</p> <p>All new admissions who are incontinent or exhibit incontinence will have a 3 day voiding dairy initiated to determine voiding patterns.</p> <p>A review of the policy for incontinence will be conducted and staff will be in-serviced on the procedure of initiating a voiding diary on admission.</p> <p>Weekly team meetings will be conducted to review residents assessments, care plan, and MDS look-back. The purpose of this meeting will be to determine completion of assessments, MDS documentation and appropriate care plan interventions.</p> <p>All new admission records will be reviewed by DON/designee to ensure voiding dairy was initiated on admission, along with the weekly meeting. This will be reported through QAPI until 100% compliance is achieved.</p>	<p>Completion: July 31, 2015 and ongoing</p>

Provider's Signature Kumi M Carr Title Administrator Date 6/29/15