

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

PRINTED: 07/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2016
NAME OF PROVIDER OR SUPPLIER STONEGATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807		
(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>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from June 27, 2016 through June 30, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 38. The Stage 2 survey sample was 22.</p> <p>Abbreviations/definitions used in this report are as follows: ADL / activities of daily living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON- Assistant Director of Nursing; aFib / Atrial Fibrillation - irregular and often rapid heart rate that commonly causes poor blood flow to the body; agitation - emotional state of restlessness; antibiotic - medication used to treat bacterial infections; anticoagulant - blood thinner/medication used to increase the time it takes for blood to clot; antipsychotic - medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; aspiration pneumonia - inflammation of the lung caused by inhaling vomit, food or liquid or other material; BIMS - Brief Interview for Mental Status/13-15: cognitively intact; 8-12: moderately impaired; 0-7: severe impairment; b/s- bedside CG /contact guard - a physical therapist needs to merely have one or 2 hands on your body parts to help balance or steady the body;</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
07/22/2016

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 cognition- thinking, memory c/o - complaint of; continent - control of bladder and bowel function; dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; DLTCRP - Division of Long Term Care Residents Protection; DON - Director of Nursing; dysphagia - difficulty swallowing; eval. - evaluation; e.g.-for example; fluctuating - unstable, rise and fall; FMD - facility maintenance director; frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period shaft of the humerus - middle part of the upper arm bone gall bladder - an organ underneath the liver that stores the bile produced by the liver; gall bladder lap resection- removal of gall bladder by laparoscopy resection - a fiber-optic instrument is inserted through a small incision on the abdomen while watching on an enlarged image of the patient's gall bladder on television monitor to remove it.; gangrenous - dead/decay tissues; hospice - service that provides care to residents that are terminally ill; hypnotic - a sleep inducing medication; hypoxic - body or region deprived of oxygen supply at tissues; L-liters; hx - history;	F 000			

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F 000	<p>Continued From page 2</p> <p>MAR - Medication Administration Record; MD-Medical Doctor; MDS / Minimum Data Set - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; neurological assessments / neuro checks - series of simple questions and physical tests to determine if the nervous system is impaired; includes Blood pressure,pulse, respiration, equality in hand grip, pupil size and reaction, level of consciousness; nc-nasal canula; Pressure Ulcer - PU-sore area of skin that develops when the blood supply to it is cut off due to pressure; plateaued - reach a state of little or no change after a time of activity or progress; rehab. - rehabilitation such as PT/OT PT/pt- Physical Therapist OT/ot- Occupational Therapist respiratory failure-not enough oxygen that passess from the lungs into the blood RN - Registered Nurse; RW- roller walker; r/t-related to; sedative - a sleep inducing medication; Stage II (2) - partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed; may also present as an intact or opened/ruptured blister; Standard Wheelchair - has 2 large rear wheels which offers greater stability and used by residents for frequent/every day use; transport chair - a light weight mobility wheelchair with smaller wheels than a standard w/c; anticoagulant Xarelto-blood thinner medication UTI / urinary tract infection - bacteria in the urine; W/C - wheel chair.</p>	F 000		

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F 246 F 246 SS=D	Continued From page 3 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by : Based on observations and interviews, it was determined that the facility failed to ensure that all call lights were within reach for three (R39, R45, and R47) out of 22 sampled residents. Findings include: The following was found during the stage 2 environmental tour on 6/28/16 from 10:30 AM to 11:00 AM: 1) R39 - The call bell cord in the bathroom was wrapped and tied to one end of the grab bar. The cord was not long enough for someone to reach and activate the bell if the person fell on the floor; 2) R45 - The call bell cord in the bathroom was wrapped and tied to one end of the grab bar. The cord was not long enough for someone to reach and activate the bell if the person fell on the floor; 3) R47 - The call bell cord in the bathroom was wrapped and tied to one end of the grab bar. The cord	F 246 F 246	All call cords in resident rooms have been inspected to assure cords are free of grab bar and accessible to residents. It was determined through an analysis of the call cord location that cords in some cases fall directly in front of the toilet paper roll. The residents wrap the cord to the side to access the toilet paper. Maintenance will move the call cord location from in front of the toilet paper roll when needed while still allowing safe access to the cord for the safety of the resident. A preventive maintenance schedule will be completed weekly rotating through the four sections of the resident rooms to assure that the cords are functioning and assess if further adjustment is necessary. The Maintenance Director will assign one maintenance person to complete this preventive maintenance checklist weekly. He will sign when complete and submit to the Maint. Director for review. The Maintenance Director will submit the completed checklist to the QAPI	8/15/16

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F 246	Continued From page 4 was not long enough for someone to reach and activate the bell if the person fell on the floor. E4 (FMD) was interviewed and confirmed the findings on 6/28/16 at 10:30 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/30/16 at approximately 3:15 PM.	F 246	committee with recommendations for further adjustments as needed. The goal will be to locate the call cords appropriately so that they are within reach of the resident while not obstructing access to personal hygiene items 100% of the time.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 8 rooms (Room 194, 207, 216, 217, 218, 221, 222, and 228) out of 29 rooms. Findings include: The following was found during the environmental tour on 6/28/16 from 10:30 AM to 11:00 AM as well as during stage 1, on June 27, 2016: Room 194 - The ceiling light by the window was out; Room 207 - The shower stall light was not working; Room 216	F 253	All ceiling lights sited during the recent survey have been replaced. All stained ceiling tiles sited have been replaced. All toilet bolts without caps have been corrected. The bathroom baseboard in room 216 with the cracked tile baseboard is scheduled for repair by August 15, 2016 Preventive maintenance has been sporadic in the past causing the above items to be overlooked. A preventative maintenance checklist has been created to address these deficient items as well as additional items that need to be monitored more closely. The Maintenance Director will be responsible for the successful implementation of a preventive maintenance review to assure that rooms are regularly checked by a member of the	8/15/16

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F 253	Continued From page 5 - The bathroom baseboard next to the shower wall had a missing section; Room 217 - The toilet had 1 missing toilet bolt cover on the left side; Room 218 - The ceiling tile above the closet was stained; Room 221 - The toilet bolts were exposed; Room 222 - 3 ceiling tiles next to the left wall has a water stain; Room 228 - 3 ceiling tiles next to the closet had a water stain E4 (FMD) was interviewed and confirmed the findings on 6/28/16 at approximately 11:00 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/30/16 at approximately 3:15 PM.	F 253	maintenance department. One staff member will be assigned to complete the inspection on a weekly basis rotating through the four sections of the resident rooms. The person will sign off on the completion and submit to the Maintenance Director for review. The Maintenance Director will submit the preventative maintenance program to the QAPI committee on a quarterly basis with a summary of items identified and corrective actions with the goal of assuring that all operational items in the resident rooms are reviewed and deficient items corrected with 100% compliance.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the	F 272		8/21/16

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F 272	Continued From page 6 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; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for three (R13, R26 and R35) out of 22 sampled residents the facility failed to ensure the comprehensive assessments were accurate and/or complete in the areas of active diagnoses and medications. Findings include:	F 272	Of the three residents whose comprehensive assessment had missing documentation, R-13's most recent MDS has been updated to include the hypnotic medication missed on the 12/2015 assessment. R-26, the MDS assessment	

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F 272	<p>Continued From page 7</p> <p>1 a. Review of R13's clinical record revealed: R13 was admitted to the facility on 12/18/15.</p> <p>Review of R13's MAR revealed the resident received medication, classified as a hypnotic, for sleep from 12/25/15 through 12/31/15.</p> <p>The admission MDS assessment, dated 12/31/15, failed to identify in Section N - Medications that R13 received a hypnotic during the seven (7) day review time period.</p> <p>The facility failed to accurately complete R13's comprehensive admission MDS assessment.</p> <p>Findings were confirmed by E3 (ADON) during an interview on 6/29/16 at approximately 4:00 PM.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON) and E3 during the exit conference on 6/30/16 at approximately 3:15 PM.</p> <p>1b. Review of R13's MAR from 3/26/16 through 4/1/16 revealed the resident received medications for depression, high blood pressure and an irregular heart rhythm requiring administration of an anticoagulant.</p> <p>The 4/1/16 Significant Change MDS assessment failed to identify in Section I - Active Diagnoses that R13 was receiving medications and/or monitoring for diagnoses of depression, high blood pressure and irregular heart rhythm.</p> <p>The facility failed to accurately complete R13's 4/1/16 significant change MDS assessment.</p> <p>Findings were confirmed by E3 (ADON) during an</p>	F 272	<p>from 3/2015 was reviewed for accuracy. R -35 the most recent MDS now indicates the resident takes a hypnotic. The facility notes, while assessments were missing documentation the medications were administered as there were physician orders in place for each resident listed in F-tag 272.</p> <p>An audit will be conducted of all residents to determine that section I and N of the MDS is completed accurately. This audit will be completed by the DON/designee. See attached audit tools (attachment A, A 1, B)</p> <p>The facility will conduct monthly audits of sections I and N of the MDS to determine that any and all changes of the medications or diagnoses be captured in the most current assessments. The audits will be completed by the MDS Coordinator /designee.</p> <p>All completed audits will be submitted to the QAPI committee. The committee will review such audits and make any recommendations for improvement of the process to the DON/designee. The audits will be completed until 100% compliance is achieved.</p>	

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F 272	<p>Continued From page 8 interview on 6/29/16 at approximately 4:00 PM.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON) and E3 during the exit conference on 6/30/16 at approximately 3:15 PM.</p> <p>2 a. Review of R26's clinical record revealed: R26 was readmitted to the facility on 3/20/16.</p> <p>A progress note, dated 3/20/16 and timed 5:55 PM, stated that R26 was ordered an antibiotic medication for a diagnosis of an UTI from 3/21/16 to 3/23/16.</p> <p>Review of the admission MDS assessment, dated 3/27/16, failed to identify in Section I - Active Diagnoses, that R26 had a current UTI.</p> <p>The facility failed to accurately complete R26's admission MDS assessment on 3/27/16. Findings were confirmed by E3 (ADON) during an interview on 6/30/16 at 9:16 AM.</p> <p>Findings were reviewed with E2 (DON) on 6/30/16 at 9:59 AM.</p> <p>2b. Review of R26's MAR revealed the resident received an antibiotic medication for an UTI from 3/21/16 to 3/23/16, a total of 3 days.</p> <p>The admission MDS assessment, dated 3/27/16, failed to identify in Section N - Medications, that R 26 received antibiotic medication during the seven (7) day review time period.</p> <p>The facility failed to accurately complete R26's admission MDS assessment on 3/27/16. Findings were confirmed by E3 (ADON) during an interview on 6/30/16 at 9:16 AM.</p>	F 272			

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F 272	Continued From page 9 Findings were reviewed with E2 (DON) on 6/30/16 at 9:59 AM. 3. Review of R35's clinical record revealed: R35 was admitted to the facility on 11/26/15. Review of R35's MAR revealed the resident received medication, classified as a hypnotic, for sleep from 3/1/16 through 3/31/16. The comprehensive significant change/annual MDS assessment, dated 3/10/16, failed to identify in Section N - Medications that R35 received a hypnotic during the seven (7) day review time period. The facility failed to accurately complete R35's comprehensive significant change/annual MDS assessment. Findings were confirmed by E3 (ADON) during an interview on 6/29/16 at approximately 10:00 AM. Findings were reviewed with E1 (NHA), E2 (DON) and E3 during the exit conference on 6/30/16 at approximately 3:15 PM.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve	F 274		8/21/16

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F 274	<p>Continued From page 10</p> <p>itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record reviews and interviews, it was determined that the facility failed to conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined that there has been a significant change in the resident's physical or mental condition for three (R17, R22, and R26) out of 22 sampled residents. Findings include:</p> <p>1. Review of R 22's clinical record revealed: R22 was admitted to the facility on 3/8/16. Due to multiple hospitalizations, an admission MDS assessment was not completed until 4/5/16. R22's admission MDS assessment, dated 4/5/16, stated the following:</p> <ul style="list-style-type: none"> - daily decision making skills were moderately impaired with a BIMS score of 9; - there were no behavioral symptoms; - walked in the room with limited assist of one (1) staff; - walked in the corridor with limited assist of one (1) staff; - had no pressure ulcers. <p>On 5/27/16, R22 was discharged to the hospital. A Discharge Return Anticipated tracking form (discharged to the hospital and return to the facility is expected) was completed on 5/27/16.</p>	F 274	<p>The facility maintains while a significant change MDS was not classified when creating a new MDS, the comprehensive assessment that was completed on R-22, R-26 and R-17 did capture the appropriate care and services necessary to implement the appropriate plan of care. Residents R-22, R-26 and R-17 have current MDS assessments which correctly identifies the appropriate type of assessment as of 7/21/16.</p> <p>The DON/designee will conduct an audit of all admissions in the last 30 days to determine if any resident admitted from the hospital should be classified as a significant change. Completion date of 8/ 21/16. See attachment C.</p> <p>All residents who have a discharge MDS with return anticipated will be placed on a significant change tracking. This will be completed with an alert charting system. All nursing staff will be in-serviced on the components of a significant decline or improvement. The alert charting system will track for 14 days to determine if the potential change is self-limiting or an actual decline or improvement.</p> <p>A weekly summary will be completed on all residents to determine if any resident</p>		

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F 274	<p>Continued From page 11</p> <p>R22 re-entered the facility on 6/2/16. Review of the clinical record revealed that an admission MDS assessment, dated 6/9/16, was again completed for R22.</p> <p>The 6/9/16 MDS assessment stated the following:</p> <ul style="list-style-type: none"> - daily decision making skills were severely impaired with a BIMS score of 3; - physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, etc.) occurred on 1 to 3 days during the review period; - walk in room did not occur; - walked in corridor with extensive assist of two (2) staff; - re-admitted from hospital with a Stage 2 pressure ulcer. <p>Although the facility completed a comprehensive admission assessment on 6/9/16, they failed to identify a significant change in R22's mental and physical status and subsequently failed to code the 6/9/16 MDS assessment as a significant change in status MDS assessment.</p> <p>During an interview with E3 (ADON) on 6/29/16 at approximately 4:00 PM, E3 stated that she thought every resident returning from the hospital got an admission MDS assessment completed.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/30/16 at approximately 3:15 PM.</p> <p>2. Review of R26's clinical record revealed: R26 was admitted to the facility on 1/5/16;</p> <p>The admission MDS assessment, dated 1/18/16, stated the following:</p>	F 274	<p>should be placed on significant change tracking. If a resident shows a decline or improvement in 2 or more areas, the resident will be placed on alert charting for 14 days. The results of the significant change tracking will be presented to the QAPI committee. The committee will review the results quarterly and make any recommendations for improvements if indicated. See attachment D</p>		

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NAME OF PROVIDER OR SUPPLIER STONEGATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807		
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F 274	<p>Continued From page 12</p> <ul style="list-style-type: none"> - R26 was not experiencing disorganized thinking; - R26 had minimal depression; - R26 was not exhibiting physical or other behavioral symptoms; and - R26 was continent of both bladder and bowel. <p>On 3/16/16, R26 was discharged to the hospital. A Discharge Return Anticipated tracking form was completed on 3/16/16.</p> <p>R26 re-entered the facility on 3/20/16. Review of the clinical record revealed that an admission MDS assessment, dated 3/27/16, was again completed for R26.</p> <p>The 3/27/16 admission MDS assessment stated the following:</p> <ul style="list-style-type: none"> - R26 had fluctuating disorganized thinking; - R26 had an increase in depression; - R26 was exhibiting physical behavioral symptoms directed toward others and other behavioral symptoms not directed toward others (e.g. screaming, hitting self); - R26's change in behaviors was worse; and - R26 was frequently incontinent of both bladder and bowel. <p>While the facility completed a comprehensive admission assessment on 3/27/16, they failed to identify that R26 declined in her physical and mental condition, specifically under mood, behaviors and bladder and bowel continence, and subsequently failed to code the 3/27/16 MDS assessment as a significant change in status MDS assessment.</p> <p>Findings were confirmed with E3 (ADON) on 6/30 /16 at 9:16 AM. The facility failed to conduct a significant change MDS assessment instead of</p>	F 274		

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F 274	Continued From page 13 an admission assessment on 3/27/16 after R26 re-entered the facility from the hospital with a decline in mood, behaviors and bladder and bowel incontinence. Findings were reviewed with E2 (DON) on 6/30/16 at 9:59 AM. 3. Review of R17's clinical record revealed: R17 was readmitted to the facility on 1/25/16. A physician's order, dated 1/25/16 and timed 10:55 PM, stated to admit R17 to hospice. A comprehensive admission MDS assessment, dated 2/3/16, was completed. However, the facility failed to code the 2/3/16 MDS assessment as a significant change in status MDS assessment as R17 elected the hospice benefit on 1/25/16. Findings were confirmed with E3 (ADON) on 6/30/16 at 9:16 AM. The facility failed to complete a significant change assessment instead of an admission assessment on 2/3/16 when R17 was enrolled in hospice. Findings were reviewed with E2 (DON) on 6/30/16 at 9:59 AM.	F 274		
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.	F 278		8/21/16

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F 278	<p>Continued From page 14</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record reviews and interviews, it was determined that for one (R35) out of 22 sampled residents the facility failed to ensure the quarterly assessments were accurate and/or complete in the areas of active diagnoses and medications. Findings include:</p> <p>Review of R35's clinical record revealed: R35 was admitted to the facility on 11/26/15.</p> <p>Review of R35's MAR revealed the resident received medication, classified as an antipsychotic, for agitation/dementia with psychotic features from 6/1/16 through 6/30/16.</p>	F 278	<p>R-35 the most recent MDS now indicates the resident takes a hypnotic. The facility notes, while assessments were missing documentation the medications were administered as there were physician orders in place.</p> <p>An audit will be conducted of all residents to determine that section I and N of the MDS is completed accurately. This audit will be completed by the DON/designee. See attached audit tools (attachment A, A 1, B)</p> <p>The facility will conduct monthly audits of sections I and N of the MDS to determine</p>	

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F 278	Continued From page 15 The quarterly MDS assessment, dated 6/9/16, failed to identify in Section N - Medications that R 35 received an antipsychotic during the seven (7) day review time period. The facility failed to accurately complete R35's quarterly MDS assessment. Findings were confirmed by E3 (ADON) during an interview on 6/29/16 at approximately 10:00 AM. Findings were reviewed with E1 (NHA), E2 (DON) and E3 during the exit conference on 6/30/16 at approximately 3:15 PM.	F 278	that any and all changes of the medications or diagnoses be captured in the most current assessments. The audits will be completed by the MDS Coordinator /designee. All completed audits will be submitted to the QAPI committee. The committee will review such audits and make any recommendations for improvement of the process to the DON/designee. The audits will be completed until 100% compliance is achieved.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		8/31/16

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F 279	Continued From page 16 This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to develop a comprehensive care plan for one (R13) out of 22 sampled residents. Findings include: R13's clinical record revealed the resident was receiving an anticoagulant (Xarelto) since admission to the facility on 12/18/15. Review of the comprehensive care plan lacked evidence that a care plan was developed for the use of the anticoagulant and the increased risk for bleeding. On 6/29/16 at approximately 4:00 PM, E3 (ADON) confirmed there was no care plan for R13's increased risk of bleeding related to use of an anticoagulant. Findings were reviewed with E1(NHA) and E2 (DON) on 6/30/16 at approximately 3:15 PM during the exit conference.	F 279	A care plan has been implemented for R-13. Bleeding precautions has been identified as the appropriate care plan and was corrected on 6/29/16 by the MDS Coordinator. All residents receiving anticoagulants have been audited for the appropriate care plan. All residents have bleeding precautions care plan/intervention in place as of 6/30/16. The facility will conduct monthly audits of any resident started on an anticoagulant to determine that a care plan has been implemented. See attachment A. All nursing staff will be in-serviced on implementing and updating care plans for those residents who receive anticoagulants. Goal of 100% compliance. All completed audits will be submitted to the QAPI committee. The committee will review results and make any recommendations for improvement to the DON/designee.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/31/16

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F 309	Continued From page 17 This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that for one (R17) out of 22 Stage 2 sampled residents, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being in accordance with R17's plan of care. For R17, the facility failed to establish a communication system to ensure that hospice exchanged information and coordinated their approach to R17's needs with the facility with respect to R17's plan of care and failed to ensure that the information was available to facility staff and other practitioners in the event that R17 was transferred to another setting for care since she enrolled in hospice on 1/26/16, over 5 months ago. Findings include: Review of R17's clinical record revealed: R17 was readmitted to the facility on 1/25/16 status post hospitalization. A physician's order, dated 1/25/16 and timed 10:55 PM, stated to admit R17 to hospice. A Nursing Facility Services Agreement with Hospice, dated 1/26/16, in reference to R17 stated, "... Plan of Care. Facility shall ensure that each Hospice Patient's written Plan of Care includes both the most recent hospice plan of care and a description of the services furnished by the Facility to attain or maintain the Hospice Patient's highest practicable physical, mental, and psychosocial well-being ... Responsibilities of the Facility ... Designation of Facility Representative ... The designated interdisciplinary team member is responsible for the following ... (iv) Obtaining	F 309	Hospice records were received for R-17 on 6/28/16 and placed in the resident's record. The facility maintains that the resident's quality of care was not affected by not having the documents from hospice. All appropriate care and services were implemented to R-17 despite hospice records being in the medical record. The nursing progress notes of R-17 did indicate there was clear communication between hospice and the facility and it has been on-going. Of the two residents currently receiving hospice services, both have the appropriate documentation in the respective medical records as of 7/21/16. Resident's who receive hospice services will have a record review weekly to determine that all appropriate documentation is in place. All nursing staff will be in-serviced on the hospice process and requirements. See attachment E. The goal for record compliance will be 100%. Audits of hospice records will be presented to the QAPI committee ongoing . The audits will be reviewed quarterly and any recommendations for improvement will be made to the DON/designee.		

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F 309	<p>Continued From page 18</p> <p>the following information from the Hospice: [a] Plan of Care, Medications and Orders. The most recent hospice Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility; [b] Election Form. The hospice election form and any advanced directives; [c] Certifications. Physician certifications and recertification of terminal illness specific to each patient; [d] Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services ... At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility: (i) Plan of Care, Medications and Orders ... (ii) Election Form ... (iii) Certifications ... (iv) Contact Information ... (v) On-Call System ... 6. Records ... Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement ... Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systematically organized to facilitate retrieval by either Party ...".</p> <p>Review of R17's clinical record revealed a yellow card in the inside cover with contact information for hospice personnel and when to call hospice. Further review of R17's clinical record revealed a Hospice tab section in the back of the chart. The only documents found under the Hospice section were signed on 1/26/16 and entitled, "Patient Family Election Statement Insurance/Self-Pay, Patient Bill of Rights and Responsibilities and the Medicare/Medicaid Hospice Election Statement</p>	F 309		

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F 309	<p>Continued From page 19 Authorization for Admission/Informed Consent".</p> <p>In an interview with E7 (Unit Clerk) on 6/28/16 at approximately 2 PM, the surveyor asked where was the facility and hospice exchange information regarding R17's Plan of Care and the Medical Director Certification of Terminal Illness. E7 stated that information was in R17's chart under the Hospice section. E7 looked at R17's chart under the Hospice section and immediately called E2 (DON).</p> <p>In an interview on 6/28/16 at 3:41 PM, E2 (DON) confirmed that the hospice communications, including the Plan of Care and the Certification of Terminal Illness, were not in R17's clinical record or in the facility. E2 stated that she called hospice and requested them to fax the information to the facility. E2 stated that hospice documents electronically.</p> <p>On 6/28/16 and timed 4:34 PM, partial hospice records were received by the facility via fax since R17's enrollment started on 1/26/16 and included the following: - The Plan of Care/Comprehensive Assessment Recertification dated 4/20/16; and - The Medical Director Certification of Terminal Illness starting 4/25/16 through 7/23/16.</p> <p>The facility failed to establish a communication system to ensure that hospice exchanged information and coordinated their approach to R 17's needs with the facility in respect to R17's plan of care and failed to ensure that the information was available to facility staff and other practitioners, in the event that R17 was transferred to another setting for care since she enrolled in hospice on 1/26/16, over 5 months</p>	F 309		

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F 309	Continued From page 20 ago. Findings were reviewed during the exit conference on 6/30/16 at 3:20 PM with E1 (NHA) and E2 (DON).	F 309			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: June 30, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual recertification survey was conducted at this facility from June 27, 2016 through June 30, 2016. 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 38. The Stage 2 survey sample size was 22.</p> <p>Regulations for Skilled and Intermediate Care 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: Cross Refer to the CMS 2567-L survey completed June 30, 2016: F246, F253, F272, F274, F278, F279 and F309.</p>		

Provider's Signature Kim M. Carr Title administrator Date 7/22/16



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<p>3201.9.0 3201.9.8 3201.9.8.4.2</p>	<p>Record and Reports</p> <p>Reportable incidents are as follows</p> <p>Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that one (R33) out of 22 Stage 2 sampled residents, incident of injury of unknown source from an unwitnessed fall was immediately reported to the DLTCRP in accordance with State law through established procedures and including the results of the investigation within 5 working days of the incident. Findings include:</p> <p>6/8/2016 00:07 - Incident Note of an incident that occurred on 6/7/16 for R33 stated, "CNA found resident lying on the floor in her room, and notified nurse. This nurse, and another nurse, responded. Residents chair alarm sounding. Resident appeared to have flipped backwards in transport chair. Chair was lying on its back, and walker was near her and flipped on its side. She was lying on her back behind the flipped transport chair, near the foot of her bed, and next to a tray table. Call bell was in reach. Resident able to move all extremities without difficulty. Resident states that she was trying to get up and get ready for dinner. When asked why she didn't ring for assistance, she responded "I'm so sorry, I know I should have rang".</p> <p>Resident states that she did hit her head, and a bump was noted to the back of her head. She first stated that her head hurt, but it resolved after a couple of minutes. Did also c/o mild left shoulder pain, however, states</p>	<p>Incident reports are reviewed for all resident injuries. Resident falls are investigated and the investigation is reviewed to determine if the fall resulted in significant injury to the resident. The parameters for reporting to the state will be reviewed with the nursing supervisors so that the requirement to report such injuries is met 100% of the time. Incidents reports are reviewed as a part of the weekly nursing meeting. It was noted that R-33 did state that she did hit her head and the documentation noted that there was a bump on the back of her head. All appropriate actions were taken by the nursing staff at the time of the injury. The family preferred for her not to be sent to the hospital. In the future, if the injury is significant to warrant a transport to the hospital, even if family declines to send, it will be considered to be reportable.</p> <p>The DON/designee will monitor compliance with this requirement through continued participation in the weekly nursing meeting.</p>	

Provider's Signature Kimberly M Carr Title Administrator Date 7/22/14



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DATE SURVEY COMPLETED: June 30, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>that it is not new. No other c/o of any pain or discomfort".</p> <p>Immediate Action taken "V/S at time of fall 99.2, 83, 20, 139/68, 94% 2L NC. Reminded resident not to ambulate unassisted. She verbalized understanding. Changed out transport chair with a W/C. Called and spoke with resident's son...who was made aware of residents fall. Explained that resident did hit her head, and since she is on Xeralto (anti-coagulant), it may be a good idea to have her seen at hospital ER for eval. Son...states that he would prefer us to keep an eye on her here for now. Neuro checks initiated. MD in the building, and made aware of all the above details".</p> <p>Review of R33's clinical record revealed that Neuro checks were done on 6/7/16-6/9/16 x 24 hrs. +.</p> <p>The facility failed to show evidence that this fall and incident that required periodic neurological assessment for 24 hours, was immediately reported to the DLTCRP including report of the results of the investigation within 5 working days as required.</p> <p>Review of the DLTCRP file on the 2016 Incident Referral Center's for list of Incidents Reported for (Name of Facility) confirmed this finding.</p> <p>This finding was discussed with E2 (DON) on 6/29/16 at approximately 4:00 PM.</p>		

Provider's Signature Kimberly M Carr Title Administrators Date 7/23/16