

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES  
PLAN OF CORRECTION

PROVIDER/SUPPLIER'S  
IDENTIFICATION NUMBER

DATE OF SURVEY

05/08/2015

085028

EL WING

05/08/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MANORCARE HEALTH SERVICES - WILMINGTON

700 POLK ROAD

WILMINGTON, DE 19803

(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)	(X3) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual recertification survey was conducted at this facility from April 22, 2015 through May 6, 2015. 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 129. The Stage 2 survey sample size was 30.</p> <p>Abbreviations used in this report are as follows:                      NHA - Nursing Home Administrator;                      DON - Director of Nursing;                      LPN - Licensed Practical Nurse;                      CNA - Certified Nurse's Aide;                      DCD - Director of Care Delivery;                      FSD - Food Service Director;                      MDS - Minimum Data Set (standardized assessment forms used in nursing homes);                      EMR - Electronic Medical Record;                      GI - Gastrointestinal;                      ADL - Activities of Daily Living (such as bathing, dressing);                      cm - Centimeter - a measurement, 1 centimeter = 0.39 inches;                      PRN (prn) - as needed;                      TAR - Treatment Administration Record;                      WCN - Wound Care Nurse;                      MD - Medical Doctor;                      QOD - every other day;                      QA - Quality Assurance;                      HOH - hard of hearing;                      NPUAP - National Pressure Ulcer Advisory Panel (authoritative voice for improved outcomes in pressure ulcer prevention and treatment through public policy, education and research);                      anemia - low red blood cell count;</p>	F 000	<p><b>F225 – INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>A. R283 – Resident's injury was reported to the Division of Long Term Care Resident's Protection (DLTCRP) on 4/23/15.</p> <p>B. The Administrative Director of Nursing Services (ADNS) will audit medical records of residents currently residing in the facility to determine if there is an injury of unknown source and use the guidelines outlined in a Memorandum dated October 3, 2013 from the DLTCRP to determine if injury was reported timely.</p>	<p>6/12/15</p>

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

TITLE

*Robert John*

*Adair*

6/12/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days from 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.

STATE OF DELAWARE  
DEPARTMENT OF HEALTH & HUMAN SERVICES

STATEMENT OF DEFICIENCIES  
REGARDING CORRECTION

FACILITY PROVIDER/SUPPLIER/REGISTRANT  
IDENTIFICATION NUMBER

DEPARTMENT OF HEALTH & HUMAN SERVICES  
LICENSURE UNIT

DATE OF SURVEY

085020

D, WING

05/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MANORCARE HEALTH SERVICES - WILMINGTON

700 FOULK ROAD

WILMINGTON, DE 19807

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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual recertification survey was conducted at this facility from April 22, 2015 through May 6, 2015. 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 129. The Stage 2 survey sample size was 30.</p> <p>Abbreviations used in this report are as follows:                      NHA - Nursing Home Administrator;                      DON - Director of Nursing;                      LPN - Licensed Practical Nurse;                      CNA - Certified Nurse's Aide;                      DCD - Director of Care Delivery;                      FSD - Food Service Director;                      MDS - Minimum Data Set (standardized assessment forms used in nursing homes);                      EMR - Electronic Medical Record;                      GI - Gastrointestinal;                      ADL - Activities of Daily Living (such as bathing, dressing);                      cm - Centimeter - a measurement, 1 centimeter = 0.39 inches;                      PRN (prn) - as needed;                      TAR - Treatment Administration Record;                      WCN - Wound Care Nurse;                      MD - Medical Doctor;                      QOD - every other day;                      QA - Quality Assurance;                      HOH - hard of hearing;                      NPUAP - National Pressure Ulcer Advisory Panel (authoritative voice for improved outcomes in pressure ulcer prevention and treatment through public policy, education and research);                      anemia - low red blood cell count;</p>	F 000	<p>F225 -- INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>A. R283 -- Resident's injury was reported to the Division of Long Term Care Resident's Protection (DLTCRP) on 4/23/15.</p> <p>B. The Administrative Director of Nursing Services (ADNS) will audit medical records of residents currently residing in the facility to determine if there is an injury of unknown source and use the guidelines outlined in a Memorandum dated October 3, 2013 from the DLTCRP to determine if injury was reported timely.</p>	<p>6/12/15</p>

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

TITLE

*Robert J. ...*

*Admin*

6/12/15

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ) PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - WILMINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 FOULK ROAD WILMINGTON, DE 19803</b>	
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F 000	Continued From page 1  Phalanx - bone of the finger or toe; Proximal phalanx - The bone of the hand found at the bottom of the finger/thumb; PU-pressure sore/ulcer - area of localized injury to the skin and/or underlying tissue usually over a bone prominence, as a result of pressure or in combination with shear; Braden Scale - tool used to determine risk for development of pressure ulcer; Spinal Stenosis - narrowing of the open spaces within the spine, which can put pressure on the nerves that travel through the spine; Proximal - nearest to the trunk; Sacrum - large triangular bone at base of spine; Coccyx - tailbone; Blanchable - skin loses redness with pressure; Non-blanchable - areas of redness that do not fade when the skin is touched and released; Incontinent - loss of control of bladder and/or bowel function; Continent- control of bladder and/or bowel function; Incontinent-loss of control of bladder and/or bowel function; Buttocks-round fleshy parts that form the lower rear of the human trunk; Friction-one object moving over another; Shear-force exerted when client is moved up in bed by being pulled; Range of Motion - extent to which a joint can be moved safely; Erythema - redness of the skin; Excoriation - superficial wearing off of the skin; Perineal (peri) - area between the thighs, the external genitals and anus; Body audit - head to toe assessment to identify changes in the skin; Medial - relating to the middle or center;	F 000	C. R283's injury was not initially reported to the DLTCRP because the facility was using the guidelines set forth in the Memorandum dated 10/3/13 from the DLTCRP which indicated that "Bruises of unknown source" were not reportable and were to be kept on file at the facility. Bruising and Swelling is not always indicative of a "Significant Injury" and patient has been noted to swing his hands and be combative during care and the facility did not suspect	

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F 000	Continued From page 2 Lateral - relating to the side; Posterior - back surface of the body; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Z-Guard - skin protectant paste; Medihoney - a wound gel used for its antibacterial and debriding properties (the process of removing nonliving tissue from pressure ulcers); Hydrocolloid dressing - a dressing with a substance that forms a gel with water/fluid; NSS - Normal Saline Solution; Serous - a thin, clear, light yellow watery fluid found in many body cavities; Granulation - A kind of tissue formed during wound healing, with a rough or irregular surface; Melgisorb Ag is a silver alginate dressing (made from seaweed) that can absorb large amounts of wound fluid. Silver kills bacteria and might be used both for preventing infection and also on wounds with signs of local infection; Tegaderm - transparent film dressing; Offload - removal of pressure from an area, example float heels; Purulent - containing pus; Stages of pressure ulcers (categorization system used to describe the severity of PUs): Stage I (1) - a reddened area of intact skin usually over a bony prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop; Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and	F 000	abuse. The Staff Development Coordinator/Designee will in service licensed nurses that injuries of unknown source that are of a suspicious nature, will be reported to the DLTCRP as required by State and Federal Guidelines. Licensed Nurses will report injuries of unknown source and of a suspicious nature to the Administrator and ADNS upon discovery.	

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F 000	Continued From page 3 sometimes to tendons and joints; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar/necrotic tissue (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); PUSH Tool - (Pressure Ulcer Healing Chart) monitors on a graph the progression or healing of a pressure ulcer.	F 000	D. Directors of Care Delivery (DCD)'s/Designee will audit suspicious injuries of unknown source daily for 4 weeks to determine that these injuries were reported to the DLTCRP as appropriate, then once weekly for two months using a Prevent tool. The Prevent tool will be reviewed by the Interdisciplinary Team (IDT) during the IDT team meeting to ensure compliance. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee (QAPI) for review and further recommendations.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  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.  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).  The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		

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F 225	<p>Continued From page 4 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 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, interviews, and review of facility documents, it was determined that the facility failed to immediately report an injury of unknown source to the State agency according to State law that had the potential for abuse for one (R283) out of 30 Stage 2 sampled residents. Findings include:</p> <p>Review of the admission MDS, dated 3/31/15, revealed R283's speech was unclear, the resident was rarely/never understood and was cognitively (mental processes; thinking) severely impaired (unable to make own decisions). This MDS also stated that the resident needed or wanted an interpreter to communicate with the doctor or healthcare staff as his preferred language was Arabic.</p> <p>A progress note dated, 4/22/15 at 6:52 PM stated, "Resident's daughter noticed resident's right thumb was bruised and swollen, this nurse assessed the thumb when touching it, resident showed grimacing of pain, Tylenol... given for pain MD notified new order x-ray to right</p>	F 225			

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STATEMENT OF DEFICIENCIES 1 PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
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F 225	<p>Continued From page 5 thumb...".</p> <p>An Incident Report dated 4/22/15, stated that R283 had a bruised and swollen right thumb.</p> <p>On 4/23/15 at 10:03 AM, in an interview with R283's daughter, she stated that yesterday at 4:30 PM -5 PM, she noticed a bruise on his right thumb. "It was not there the day before. I don't know how it happened. They told me they did not know how it happened but maybe when he is moving his hands." She also stated that her father was unable to tell her how it happened.</p> <p>Review of the Investigation Report, dated 4/23/15, revealed the following events: - 4/22/14 at approximately 6:00 PM while assisting resident with bed bath, CNA observed bruised area on resident right thumb finger and notified the nurse; - 4/22/14 at approximately 6:01 PM resident was assessed by nurse, right thumb noted to be bruised, swollen and painful to touch. Resident was medicated appropriately for pain with positive results; - 4/23/15 at approximately 10:40 AM x-ray results received with a conclusion of a small chip fracture at the base of proximal phalanx; - 4/23/15 at 11:08 AM E2 (DON) submitted an Incident report to the State Agency.</p> <p>On 5/6/15 at approximately 12:00 PM, E7 (Corporate Nurse) stated that as soon as they found out the results of the X-Ray and saw that it was a significant injury of unknown source, they reported it to the State agency.</p> <p>Although the facility began to obtain statements regarding the occurrence, they failed to recognize</p>	F 225	<p><b>F248 - ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT</b></p> <p><b>A. R18 – Resident’s Activity Careplan has been reviewed and modified as appropriate and Daily Recreation Activity Log has been updated to accurately reflect participation in Activities.</b></p> <p><b>B. The Activity Director will audit patient Activity Careplans to ensure that Activity Careplans identifies resident’s interests, preference and abilities.</b></p>		

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F 225	Continued From page 6 this as having the potential for abuse and failed to report it within 8 hours to the State Agency (as required by State Law). The facility did not report it for 17 hours.  Findings were reviewed during the exit conference with E1 (NHA), E2, E7 (Corporate Nurse), and E8 (Regional Director) on 5/6/15 at approximately 12:15 PM.	F 225	C. R18's Recreation Activity Log was not updated to accurately reflect resident's participation in Activities and the Activity Assistant coordinating the specific program did not realize that the resident's careplan called for the resident to be seated closer to the leader of the program. The Staff Development Coordinator/Designee will inservice the Activity Director and Activity Assistants that resident's should participate in Activities that are consistent with the	
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 (R18) out of 30 Stage 2 sampled residents, was provided 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 this resident. Findings include:  Review of R18's "Activity Preferences" as provided by a family member, on the admission MDS assessment, dated 2/5/15, revealed that R18's interests included: listen to music, do things with groups of people, do favorite activities, go outside to get fresh air when weather was good and participate in religious	F 248		

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F 248	<p>Continued From page 7 services or practices.</p> <p>According to the care plan initiated on 2/9/15 entitled, "(R18) has confusion. She enjoys activities such as religious programs, sensory stimulation and observing group programs. She has decreased vision and is HOH. She often mumbles or is unable to finish her sentences". The care plan goal stated, "Will participate in/observe activities that promote socialization with peers consistent with likes and interests such as manicures, music and religious program". The care plan interventions included: Arrange for seating closer to leader of activity programs as patient is hard of hearing; Encourage participation in group activities of interest; Offer redirection and diversion as needed; Offer/supply large print materials; Provide supplies/materials for leisure activities as needed/requested.</p> <p>R18's "Recreation Activity Logs" were reviewed for 2/15, 3/15, 4/15 revealing that the goals consistent with R18 's interests were rarely provided as listed on the care plan. For the month of February 2015, the resident attended music/singing only 2x (times), sensory stimulation 1x, religious activities 5x as a passive participant, exercise 1x as a passive participant, and television 5x. R18's family member consistently visited to feed the resident lunch. For the month of March 2015, the resident attended music and singing 2x, religious activities included 2x active participation, 2x passive and 3x unavailable, television 4x and sensory stimulation 3x. April 2015, the resident attended music/singing 1x, television 3x, sensory stimulation 3x (out of 17 occurrences) with no religious activities. The April 2015 Activities Calendar did show there were 2 Religious Activities held on Saturdays, 5 Bible</p>	F 248	<p>resident's Activity Care Plan and that all Activity must be maintained on the Recreation Activity Log. The Activity Director will discuss concerns with Activities participation with the IDT during the IDT meeting.</p> <p>D. The Activity Director will audit Recreation Activity Logs Daily times 4 weeks for appropriate participation then once weekly for 2 months. The Activity Director will randomly audit the Activity Careplan of 10 residents weekly times 12 weeks to ensure that Activity Careplan continues to be appropriate to resident's interests, preferences, and abilities. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee (QAPI) for review and further</p>	

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F 248	Continued From page 8 Stories held on Wednesdays.  On 4/30/15 at approximately 11:00 AM, R18 who was hard of hearing, was observed in the activity room in her wheelchair at a table alone, dozing on and off. R18 was not seated close to the leader of the activity program as per the plan of care.  On 5/1/15 at approximately 11:00 AM, R18 was observed in her wheelchair in the activity room alone by a table, dozing on and off. There was no activity occurring. Around 12:00 PM, a family member came to pick her up and took her to the unit's lounge area to wait for lunch to be served.  In an interview with E10 (Director of Activities) on 5/5/15 at approximately 11:00 AM, she stated that the resident received communion regularly. However, the resident's "Daily Recreation Activity Participation Documentation" log did not reflect that.  R18 was also observed on 5/4/15, 5/5/15 and 5/6/15 between 10:30 AM to 11:30 AM in her room seated in a wheelchair alone, facing the wall of the room with the television off. No sensory stimulation/diversion was being provided as per the plan of care.  This finding was discussed with E1 (NHA), E2 (DON) and E8 (Regional Director) on 5/6/15 at approximately 11:30 AM.	F 248	F253 – HOUSEKEEPING & MAINTENANCE SERVICES  A. Housekeeping and Maintenance services were addressed in rooms 107A, 126A, 127C, 132A, 135A, 137A, 139A, 203, 204A, 209A, 211A, 224A, 225A, 229B, 232B, 237A, 239B, and 243A.  B. <u>The</u> Maintenance Director and Housekeeping Manger will conduct an audit to evaluate need for repairs and/or cleaning	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - WILMINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 FOULK ROAD WILMINGTON, DE 19803</b>	
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F 253	Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on observations of resident rooms during Stage I of the survey, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain an orderly interior for eighteen (107A, 126A, 127C, 132A, 135A, 137A, 139A, 203, 204A, 209A, 211A, 224A, 225A, 229B, 232B, 237A, 239B, and 243A) out of 40 rooms reviewed. Findings include:  1. On 4/22/15 at 2:39 PM the following were noted in room 239B: - peeling paint on the wall by the air conditioner/heating system; - dark discoloration along the wall in front of the bed; - air conditioner vent was dirty and had debris in it; - door of armoire was misaligned due to one bottom drawer not closing completely and the armoire door handle was broken; - debris on the bathroom floor behind the toilet.  2. On 4/23/15 at 11:20 AM there were chunks missing from the chair rail behind the headboard in room 225A.  3. On 4/23/15 at 12:57 PM the following were noted in room 232B: - air conditioner vent was dirty and had debris in it; - wall in the bathroom had a long scrape and peeling paint; - at the entrance of the room, there was a cracked floor tile;	F 253	C. Issues identified during the survey had not yet been brought to the attention of the Maintenance Director and the Housekeeping Manager. The Staff Development Coordinator /Designee will re-inservice the Maintenance Director and Housekeeping Manager regarding facility rounds for identification of need repairs and cleaning. Additionally, the Maintenance Director and Housekeeping Manager will utilize Daily Room Rounds Audit Tools for tracking necessary repairs and cleaning.	

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F 253	Continued From page 10 - window did not open, the lever to unlock the window did not lift, preventing the window from opening.  4. On 4/23/15 at 1:39 PM along the wall, in front of the bed, there was a dark discoloration in room 237A.  5. On 4/23/15 at 2:39 PM there were scrapes and torn wall paper along the wall in front of the bed in room 229B.  6. On 4/23/15 at 2:50 PM there were scrapes in the wallpaper and a dark discoloration of the wall in room 243A.  7. On 4/23/15 at 3:45 PM there was torn wall paper in the bathroom, directly in front of the sink in room 224A.  8. On 4/22/15 at 12:45 PM, the wallpaper across from the bed was ripped in numerous areas and the paint was off on the baseboard in room 209A.  9. On 4/22/15 at 2:15 PM, the air conditioner/heating unit had a dusty vent, there was dirt around the base of the toilet, the bathroom door was not aligned and did not close fully, and the bathroom door handle was loose in room 126A.  10. On 4/22/15 at 2:31 PM, the bathroom wall to the right of the toilet was plastered and unpainted in room 127C.  11. On 4/23/15 at 9:28 AM, sections of the baseboard were not painted, and a few pieces of wallpaper were torn off in room 204A.	F 253	D. The Maintenance Director and Housekeeping Manager / Designees will complete Daily Room Rounds Audit Tools for one room on each unit daily to identify any maintenance and/or housekeeping areas requiring attention for 12 weeks. The Administrator/Designee will randomly audit one Daily Rounds Audit Tool weekly to ensure that areas identified have been corrected for 12 weeks. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee (QAPI) for review and further recommendations.		

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F 253	<p>Continued From page 11</p> <p>12. On 4/23/15 at 10:39 AM, the inside of the bedside lamp shade's plastic was torn up in room 135A.</p> <p>13. On 4/23/15 at 12:27 PM, the wallpaper was in disrepair to the right of the bed and on the wall across from the bed, the privacy curtain was soiled with a brown stain, and the bathroom ceiling over the toilet had peeling paint in room 137A.</p> <p>14. On 4/23/15 at 12:32 PM, the night stand top drawer was in disrepair, with the handle off on one side in room 139A.</p> <p>15. On 4/23/15 at 2:19 PM, the baseboard and chair rail were gouged and unpainted, the wall across the bed had three (3) holes on it, and wallpaper was ripped in room 203.</p> <p>16. On 4/23/15 at 2:53 PM, there was no pull cord in the bathroom, and the air conditioner/heating unit vents were dirty and dusty in room 132A.</p> <p>17. On 4/23/15 at 3:13 PM, there were holes in the wall adjacent to the television, and wallpaper was ripped in room 211A.</p> <p>18. On 4/23/15 at 1:43 PM, there were six (6) nail holes next to the bathroom mirror, strips on the lower left side of the bathroom sink were peeling off, and there was a stain on the upper right side of the sink in room 107A.</p> <p>During the exit conference on 5/6/15 at approximately 12:00 PM, the above findings were attempted to be reviewed. E1 (NHA) stated he already heard the findings during the</p>	F 253		

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F 253	Continued From page 12 environmental tour conducted by another surveyor on 4/27/15.	F 253	<b>F256 – ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS</b>	
F 256 SS=E	<b>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS</b>  The facility must provide adequate and comfortable lighting levels in all areas.  This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to provide adequate and comfortable lighting levels in all areas for ten (10) (127B, 208A, 204, 135A, 134B, 141A, 138A, 139A, 127C and 132A) out of 40 resident rooms. Findings include:  During Stage 1 of the survey the following were observed:  1. On 4/22/15 at 2:11 PM, one of three settings of the over bed light was not working in room 127B.  2. On 4/22/15 at 4:01 PM, the nightstand lamp next to the bed did not work in room 208A.  3. On 4/23/15 at 9:28 AM, there was no pull cord extender on the over bed light, just a two to three inch chain, in room 204.  4. On 4/23/15 at 10:39 AM, there was no pull cord for the over bed light in room 135A.  5. On 4/23/15 at 11:14 AM, only one of three light settings of the over bed light was working and the nightstand lamp next to the bed was not working in room 134B.	F 256	A. Overbed lighting and lamp concerns were addressed in rooms 127B, 208A; 204, 135A, 134B, 141A, 138A, 139A, 127C, and 132A.  B. The Maintenance Director will conduct an audit to evaluate any other concerns with overbed lights or lamps.  C. Issues identified during the survey had not yet been brought to the attention of the Maintenance Director. Two lamps were not plugged in but were in fact working. The Staff Development Coordinator/Designee will in-service the Maintenance Director regarding facility rounds for identification of issues with lighting in patient rooms.	

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F 256	Continued From page 13  6. On 4/23/15 at 11:38 AM, the bottom light setting of the over bed light was not working in room 141A.  7. On 4/23/15 at 12:03 PM, the upper setting of the over bed light was not working in room 138A.  8. On 4/23/15 at 12:32 PM, the bottom setting of the over bed light was not working in room 139A.  9. On 4/23/15 at 2:31 PM, there was no pull cord for the over bed light and the nightstand lamp next to the bed did not work in room 127C.  10. On 4/23/15 at 2:45 PM, the nightstand lamp next to the bed was not working and was plugged into the outlet in room 132A.  During the exit conference on 5/6/15 at approximately 12:00 PM, the above findings were attempted to be reviewed. E1 (NHA) stated he already heard the findings during the environmental tour conducted by another surveyor on 4/27/15.	F 256	Additionally, the Maintenance Director will utilize Daily Room Rounds Audit Tools for tracking necessary resolution of lighting issues.  D. The Maintenance Director will complete Daily Room Rounds Audit Tools for one room on each unit daily to identify any lighting issues for 12 weeks. The Administrator/Designee will randomly audit one Daily Rounds Audit Tool weekly to ensure that lighting issues identified have been corrected for 12 weeks. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee (QAPI) for review and further recommendations.	
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 resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272		

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F 272	Continued From page 14 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, it was determined that the facility failed to provide a complete and accurate assessment of one (R18) out of 30 Stage 2 sampled residents, in the area of skin condition as documented on the facility's 1/29/15 "Patients Admission/Readmission Screen" form. Findings include: Cross-refer to F314	F 272	<b>F272 – COMPREHENSIVE ASSESSMENTS</b>  A. R18 has a current and accurate assessment completed of her skin by a licensed nurse.  B. The Administrative Director of Nursing Services (ADNS)/Designee will audit medical record of residents currently residing in the facility to ensure that a current and accurate assessment of resident's skin has been conducted and appropriately documented.		

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F 272	Continued From page 15 Review of R18's clinical record revealed an admission date of 1/29/15, from an out of state facility, with diagnoses that included surgical repair of a broken hip, heart disease, dementia and spinal stenosis.  Review of R18's skin assessment on the facility's Admission Screen form, dated 1/29/15, revealed that this resident's coccyx was assessed as "slight red area"; right buttock as "redness of 7 cm x 0.2 cm"; left buttock as "red area 3 cm x 3 cm"; second left buttock area as "redness 6 cm x 1 cm"; right thigh (rear) as "red area measuring 2.8 cm x 0.2". All of the above areas failed to identify whether the red areas were blanchable or non-blanchable, which would indicate the area was a pressure ulcer. Additionally, the right heel and left heel were assessed as "dry skin".  On 1/30/15, the right and left heel were re-assessed as non-blanchable redness and as an existing pressure ulcer. A nurse's note, dated 1/30/15, stated "right heel is noted with a non-blanchable reddened area measuring 3x5 cm, the left posterior lateral heel was noted with a non-blanchable reddened area measuring 5x6 cm." A nurse's note, dated 2/4/15 and timed 2:28 PM, stated "Stage 1 pressure ulcers to bilateral heels noted resolved."  During an interview with E2 (DON) and E7 (Corporate Nurse) on 4/30/15 at approximately 9:10 AM, E2 stated they were identified in their QA and that the facility had issues with wound assessment, skin assessment and weekly tracking.	F 272	C. The licensed nurse that assessed Resident 18 at time of admission assessed resident's heel differently than the Wound Care Nurse who assessed resident's heel less than 24 hours after admission. The Staff Development Coordinator/Designee will re-inservice licensed nurses on thoroughly assessing each newly admitted resident's skin condition and completing the comprehensive assessment accurately related to skin. The Wound Care Nurse will review the initial admission skin assessment and conduct a follow-up skin assessment for newly admitted residents. Additionally the IDT will review skin assessments during IDT meetings to identify any potential discrepancies in skin assessments and follow-up as necessary.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	<p>Continued From page 16</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, review of facility documentation, and family/staff interview, it was determined that the facility failed to ensure that the services were provided for pressure ulcers according to the written plan of care for one (R18) out of 30 Stage 2 sampled residents. Findings include: Cross -refer to F314</p> <p>1. R18 was admitted to the facility on 1/29/15, from an out of state facility, with diagnoses that included surgical repair of a broken hip, heart disease, dementia and spinal stenosis.</p> <p>R18's physician's ordered on 1/29/15, "Body audit (to assess) every day shift every Thursday for skin observation".</p> <p>The facility initiated care plan #1, dated 1/30/15, for "At risk for alteration in skin integrity related to: Incontinence, impaired mobility, recent surgery. The care plan goals were "Skin will remain intact, free from erythema, breakdown, excoriation or bruising..." Interventions included: barrier cream to peri-area/buttocks as needed; Encourage to reposition as needed; use assistive devices as needed; float heels as able; Observe skin condition with ADL care daily, report abnormalities; provide preventative skin care routinely and prn; Use pillow/positioning devices as needed..." This care plan did not address</p>	F 282	<p>D. The Administrative Director of Nursing Services/Designee will conduct dally audits of newly admitted residents for accuracy of the comprehensive assessment related to skin for 4 weeks, then once weekly for 2 months. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee for review and further recommendations.</p> <p><b>F282 – SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>A. R18's is currently receiving appropriate treatment according to physician orders and plan of care</p>	

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F 282	<p>Continued From page 17</p> <p>R18's history of a healed Stage 2 pressure sore on the sacrum and the potential problem for friction and shear to include individualized interventions such as "Reposition frequently in bed and chair, Manage incontinence with toileting programs, Use patient positioning device to reduce friction and shear and complete thorough skin observations".</p> <p>According to R18's admission MDS assessment, dated 2/5/15, this resident's skills for daily decision-making were severely impaired and she was always incontinent of bowel and bladder. This same MDS stated R18 required extensive assist of two (2) staff for bed mobility and transfer, and extensive assist of one(1) staff for eating, toilet use and hygiene. R18 did not walk in the room or corridor and was noted to have a functional limitation in range of motion of both upper and lower extremities on both sides of the body. The 2/5/15 MDS assessment also stated R18 was at risk for developing a pressure ulcer and had two (2) Stage 1 pressure ulcers (right and left heels according to the 1/30/15 skin assessment note) and had moisture associated skin damage (MASD).</p> <p>On 2/11/15 (3:18 PM) Wednesday, a 0.3cm x 3 cm excoriation was found on R18's right lateral buttock." Z-guard was initiated as the facility's barrier cream of choice to be applied to R18's excoriated right lateral buttock. In addition, on 2/11/15, a "Skin Alteration Record" was set up to record results/assessments of R18's excoriated right lateral buttock in accordance with the physician's order.</p> <p>On 2/11/15, a care plan entitled, "Excoriation to right lateral buttock..." was developed with the</p>	F 282	<p>B. Residents currently residing in facility that are frail, have advanced age, and whose skin is already compromised have the potential to be impacted. The Administrative Director of Nursing Services/Designee will audit medical record of resident's currently in facility to ensure that treatments and plan of care is appropriate to patient.</p> <p>C. The facility failed to follow the Skin Practice Guide for R18. The Staff</p>		

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F 282	<p>Continued From page 18</p> <p>goal to heal without complication. Interventions included: "Administer treatment per physician orders; Encourage and assist as needed to turn and reposition; Use assistive devices as needed; Report evidence of infection...; Use pillow and/or positioning devices as needed...".</p> <p>On 3/2/15 (2:13 PM), the physician ordered a new treatment to "Cleanse open area on right buttock with NSS, apply Medihoney hydrocolloid every day shift every 3 days which was transcribed in R18's TAR.</p> <p>Review of the TAR revealed the right buttock treatment was signed off as completed on 3/6/15, four (4) days after the initial treatment on 3/2/15, instead of three (3) days as ordered. The treatment failed to be signed off on 3/9/15 and was not signed off until 3/12/15, resulting in a total of five (5) days between treatments. Review of progress notes revealed no mention of the right buttock area during this time frame. The EMR lacked evidence that treatments were completed as ordered.</p> <p>The next Skin Alteration Record was dated 3/18/15 and noted a size of 0.5 cm x 0.5 cm with a scant amount of clear serous drainage and the skin surrounding the alteration was "firm/hard." However, this document failed to identify what area was being assessed. Additionally, there was no evidence that the physician and/or WCN were notified regarding the changes of the area.</p> <p>Review of the TAR revealed the right buttock treatment was signed off completed as ordered from 3/12/15 through 3/21/15. On 3/24/15 the treatment was not signed off as completed. The next treatment signed off completed was on</p>	F 282	<p><b>Development Coordinator/Designee will inservice licensed nurses on the Skin Practice Guide to include positioning and off loading heels. The Staff Development Coordinator/Designee will inservice licensed nursing staff on skin assessments upon admission and weekly thereafter or daily if compromised. The Staff Development Coordinator will in-service licensed nursing staff on documentation of wounds/alteration of skin integrity to include notifying MD, Family and Wound Team Coordinator if new area or area</b></p>	

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F 282	<p>Continued From page 19</p> <p>3/27/15, resulting in a total of five (5) days between treatments. The facility failed to consistently complete wound treatments as ordered.</p> <p>The next Skin Alteration Record (same document used for the 3/18/15 weekly assessment that failed to identify the area being assessed), dated 4/8/15, noted a size of 2 cm x 2 cm with reddened skin surrounding the alteration. There was no evidence that the skin alteration on the right buttock had been assessed for three (3) weeks from 3/18/15 through 4/8/15. Review of progress notes from 3/18/15 through 4/7/15 lacked any mention of the right buttock skin alteration.</p> <p>A Skin progress note (Late Entry), dated 4/8/15 and timed 5:00 PM, stated "Open area on right buttock measures 4.6 x 2.8 cm. Tissue type is 40% granulation, 50% dark yellow slough, 10% necrotic. Wound is moist with drainage that is light blue green. Discussed with (name of physician) new treatment order given."</p> <p>According to the facility Skin Practice Guide, the presence of a pressure ulcer required daily body audits by a licensed nurse. Review of the electronic TAR revealed that the weekly body audit was completed on 4/9/15, however there were no daily body audits completed from 4/10/15 through 4/13/15.</p> <p>On 4/14/15, care plan #2 was initiated for "open wound at right posterior hip related to: impaired mobility with new interventions added such as "Special mattress/cushion on bed/wheelchair (specify location); Report evidence of infections such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn."</p>	F 282	<p>worsens. The Staff Development Coordinator/Designee will inservice C.N.A.'s and licensed nursing staff on properly completing a body assessment/ bath sheet and documenting findings to include in Alerts and 24 hour reports. The Staff Development Coordinator/Designee will inservice licensed nursing staff on need to complete a head to toe body audit upon weekly/daily skin checks. The IDT will review skin integrity issues during the IDT meeting as issues are identified.</p> <p>D. Director of Care Delivery (DCD's)/Designee will complete facility wide skin sweeps weekly times 3 weeks. DCD's/Designee will randomly validate accuracy of C.N.A. skin worksheets for 10 residents weekly times 4 weeks then monthly times 2 months. DCD's/Designee</p>	

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F 282	<p>Continued From page 20</p> <p>This care plan failed to identify the type of wound the open area was, such as pressure ulcer, nor did it identify the stage of the wound.</p> <p>This finding was discussed with E2 (DON) and E7 (Corporate Nurse) on 4/30/15 at approximately 9:10 AM.</p> <p>The following observations were made of R18's turning and positioning: 4/27/15 R18 was observed in bed and was laying on her right side from 10:30 AM until 12:00 PM. At 1:00 PM, R18 was seated in a wheelchair in the lounge area with a family member. R18 was observed to be leaning more on the right side of the hip. Her left inner knee was pressed against the right inner knee, causing her weight to be shifted onto the right hip (close to the site of the wound) while sitting in the chair. 4/28/15 was seated in a wheelchair at around 12:00 PM to 2:00 PM, R18 remained in the same position with her weight shifted onto her right side. Position was not observed to be shifted or offloaded. 4/29/15 remained seated in wheelchair from approximately 11:30 AM to 2:00 PM. Position was not observed to be shifted or offloaded. In an interview with E9 (CNA) on 4/29/15 at approximately 2:00 PM, she stated that she was not aware that R18's position needed to be shifted when she was seated in a wheelchair. E9 stated that she did not shift R18's position when she was seated in the wheelchair. This finding was discussed with E1 (NHA) and E2 on 5/6/15 at approximately 11:30 AM. The facility failed to provide services based on the plan of care related to the development of alteration in R18's skin and the development of an unstageable pressure ulcer.</p>	F 282	<p>will randomly validate completion and accuracy of Skin Alteration Sheets on 10 residents weekly times 4 weeks, then monthly times 2 months. The IDT will review Admission Skin Assessments in the IDT meeting to ensure accuracy and completion of documentation, with a 2<sup>nd</sup> skin assessment completed by the Wound Care Nurse where deemed necessary. DCD's/Designee will randomly observe 10 residents, weekly times 4 weeks then monthly times 2 months to observe positioning. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee for review and further recommendations.</p>	

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R133) out of 30 Stage 2 sampled residents, the facility failed to implement physician's orders when a GI consult was ordered and failed to be scheduled. Findings include:</p> <p>A physician's progress note, dated 4/9/15, stated R133 was having occasional nausea and vomiting on and off, anemia was stable, and that her oral intake was decreased.</p> <p>A physician's order, dated 4/9/15, ordered R133 to have a GI consult. Review of the clinical record (hard copy and EMR) lacked evidence that the GI consult was scheduled as ordered.</p> <p>On 4/27/15 at approximately 11:30 AM, E4 (DCD) was questioned regarding results of the GI consult ordered on 4/9/15. E4 stated she would find out. On 4/30/15 at 1:00 PM during an interview with E4, she stated the physician wrote an order to cancel the GI consult. When asked if the GI consult was ever scheduled, she stated no and when asked if it was supposed to be scheduled, but never was, she then stated yes it should have been scheduled.</p>	F 309	<p>F309 – PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>A. R133's order for a GI consult was discontinued by resident's treating physician on 4/28/15 as the physician did not deem the consult necessary.</p> <p>B. The Administrative Director of Nursing Services (ADNS)/ Designee will audit medical record of residents currently residing in the facility to ensure that any consults ordered by the treating physician have been follow-up on and scheduled.</p>	

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F 309	Continued From page 22	F 309			
F 314 SS=G	<p>On 5/6/15 at 10:06 AM in an interview, E2 (DON) stated that there is no evidence that a GI consult was scheduled when ordered on 4/9/15.</p> <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, interview and review of other documentation as indicated, it was determined that the facility failed to ensure that one (R18) resident out of 30 Stage 2 sampled, who entered the facility without a pressure sore did not develop an avoidable pressure sore. Additionally, the facility failed to ensure that a resident having pressure sores receives the necessary care and services to promote healing, prevent infection and prevent new sores from developing. Findings include:</p> <p>The facility's "Skin Practice Guide," issue date 01/2013, stated risk factors for the development of pressure ulcers included immobility, friction and shear forces and excessive moisture conditions. Prevention Interventions included "Reposition frequently in bed and chair, use</p>	F 314	<p>C. The GI consult for R133 had not been followed-up on and scheduled timely as required by the facility. The Staff Development Coordinator/Designee will inservice licensed nursing staff on timely follow-up and scheduling of physician orders for outside of facility medical consults. Director of Care Delivery's for each unit will review resident medical records to ensure all orders are followed-up on as appropriate. Additionally, the IDT will review new orders for</p> <p>consults during IDT meetings to identify when new consults have been ordered by physicians and will track when appointments have been scheduled.</p>		

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F 314	<p>Continued From page 23</p> <p>barrier cream products, manage continence with toileting programs, use patient positioning device to reduce friction and shear, select appropriate support surfaces, and complete thorough skin observations." Initial evaluation included, "review the hospital discharge records, transfer sheets or other data regarding the patient's history of, or risk factors for skin alterations and pressure ulcer development...The Braden Scale...used to identify potential levels of risk for pressure ulcer development....The Braden Scale is completed for four (4) weeks total (at the time of admission and then weekly for the next three (3) weeks), quarterly, with a significant change and as clinically indicated...even a score that indicates no risk does not guarantee that a person will not develop a pressure ulcer, especially if their condition changes...A weekly skin evaluation is completed by the licensed nurse for those patients identified as at risk for skin breakdown that do not have a pressure ulcer. Daily skin evaluations are completed by the licensed nurse for those patients with pressure ulcers. Documentation of skin evaluations is completed on the Treatment Administration Record".</p> <p>According to the NPUAP prevention interventions included: Reposition frequently in bed and chair; manage incontinence with toileting programs; use patient positioning devices to reduce friction and shear; and complete thorough skin observations.</p> <p>R18 was admitted to the facility on 1/29/15, from an out of state facility, with diagnoses that included surgical repair of a broken hip, heart disease, dementia and spinal stenosis. Review of R18's discharge instructions from the out of state facility included a physician's order, dated 12/19/14, for a daily treatment of a Stage 2</p>	F 314	<p>D. The Administrative Director of Nursing Services/Designee will audit physician orders for consults daily for 12 weeks to ensure that any physician orders for consults have been scheduled. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee for review and further recommendations.</p> <p>F314 – TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>A. R18's is currently receiving appropriate treatment according to physician orders and plan of care</p>	

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F 314	<p>Continued From page 24</p> <p>pressure sore on the sacrum. This area was healed at the time of R18's transfer.</p> <p>The facility "Patient Admission" screen, dated 1/29/15 and timed 7:14 PM, stated in the area of skin assessment, "coccyx slight red area...right buttock redness of 7 cm x 0.2, left buttock red area 3cm x 3 cm, left buttock redness 6cm x 1 cm and right thigh (rear) red area measuring 2.8cm x 0.2." This skin assessment failed to note the measurement of the red area on the coccyx, and failed to identify whether all the reddened areas were blanchable or non-blanchable.</p> <p>The Braden Scale, dated 1/29/15, indicated R18's score was 16, or low risk (score of 15 to 18) for skin breakdown.</p> <p>A physician's order, dated 1/29/15, stated R18 was to have a Body audit every Thursday on the 7 AM to 3 PM shift.</p> <p>The facility initiated care plan #1, dated 1/30/15, for "At risk for alteration in skin integrity related to: Incontinence, impaired mobility, recent surgery. The care plan goals were "Skin will remain intact, free from erythema, breakdown, excoriation or bruising..." Interventions included: barrier cream to peri-area/buttocks as needed; Encourage to reposition as needed; use assistive devices as needed; float heels as able; Observe skin condition with ADL care daily, report abnormalities; provide preventative skin care routinely and prn; Use pillow/positioning devices as needed..." This care plan did not address R18's history of a healed Stage 2 pressure sore on the sacrum and the potential problem for friction and shear to include individualized interventions such as "Reposition frequently in</p>	F 314	<p>B. Residents currently residing in facility that are frail, have advanced age, and whose skin is already compromised have the potential to be impacted. The Administrative Director of Nursing Services/Designee will audit medical record of resident's currently in facility to ensure that treatments and plan of care is appropriate to patient.</p> <p>C. The facility failed to follow the Skin Practice Guide for R18. The Staff Development Coordinator/Designee will inservice licensed nurses on the Skin Practice Guide to include positioning and off loading heels. The Staff Development Coordinator/Designee will inservice licensed nursing staff on skin assessments upon admission and weekly thereafter or daily if compromised. The Staff</p>	
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F 314	<p>Continued From page 25</p> <p>bed and chair, Manage incontinence with toileting programs, Use patient positioning device to reduce friction and shear and complete thorough skin observations".</p> <p>A progress note, completed by E3 (WCN) on 1/30/15 and timed 2:49 PM stated, "Skin assessment completed...bilateral buttocks are red and blanchable...The right heel is noted with a non-blanchable reddened area medially measuring 3x3cm in size. The left posterior lateral heel is also noted with a non-blanchable reddened area measuring 5x6cm in size...remaining bony prominences free of abnormality...requires assist of one to turn side to side in bed..." A progress note completed by E3, dated 2/4/15 and timed 2:28 PM, stated "Stage 1 pressure ulcers to bilateral heels noted resolved..."</p> <p>According to R18's admission MDS assessment, dated 2/5/15, this resident's skills for daily decision-making were severely impaired and she was always incontinent of bowel and bladder. This same MDS stated R18 required extensive assist of two (2) staff for bed mobility and transfer, and extensive assist of one(1) staff for eating, toilet use and hygiene. R18 did not walk in the room or corridor and was noted to have a functional limitation in range of motion of both upper and lower extremities on both sides of the body. The 2/5/15 MDS assessment also stated R18 was at risk for developing a pressure ulcer and had two (2) Stage 1 pressure ulcers (right and left heels according to the 1/30/15 skin assessment note).</p> <p>2/5/15 - Review of the February TAR revealed that the body audit was signed off as completed.</p>	F 314	<p>Development Coordinator will in-service licensed nursing staff on documentation of wounds/alteration of skin integrity to include notifying MD, Family and Wound Team Coordinator if new area or area worsens. The Staff Development Coordinator/Designee will inservice C.N.A.'s and licensed nursing staff on properly completing a body assessment, bath sheet and documenting findings to include in Alerts and 24 hour reports. The Staff Development Coordinator/Designee will inservice licensed nursing staff on need to complete a head to toe body audit upon weekly/daily skin checks. The IDT will review skin integrity issues during the IDT meeting as issues are identified.</p>	

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F 314	<p>Continued From page 26</p> <p>A progress note, dated 2/9/15 and timed 11:24 AM, stated "...assisted with shower skin intact No open areas..."</p> <p>A progress note, dated 2/11/15 (Wednesday) and timed 3:18 PM, stated "...0.3cm (length) x 0.3cm (width) excoriation observed on right lateral buttock, new order received...to apply Z-guard..."</p> <p>A Skin Alteration Record (not used for assessment of pressure ulcers) was initiated on 2/11/15 for "Excoriation Right Lateral buttock" and was to be completed weekly according to directions on the record and the facility Skin Practice Guide.</p> <p>Review of the EMR for CNA documentation revealed that although Z-Guard was listed on 2/11/15 as part of the tasks they were to complete, it was not designated as a task that required a signature when completed.</p> <p>2/12/15 and 2/19/15- Review of the February TAR revealed that the body audits were signed off as completed.</p> <p>Review of the Skin Alteration Record for the right lateral buttock excoriation revealed that the next assessment was not completed until 2/25/15, two (2) weeks later. Review revealed that the size had increased to 0.5cm x 0.5cm.</p> <p>2/26/15 - Review of the February TAR revealed that the body audit was signed off as completed.</p> <p>The Skin Alteration Record for the right buttock excoriation was next completed on 3/2/15, five (5) days later and the documented size was 0.6cm x 0.8 cm, again increasing in size. A progress note,</p>	F 314	<p>D. Director of Care Delivery (DCD's)/Designee will complete facility wide skin sweeps weekly times 3 weeks. DCD's/Designee will randomly validate accuracy of C.N.A. skin worksheets for 10 residents weekly times 4 weeks then monthly times 2 months. DCD's/Designee will randomly validate completion and accuracy of Skin Alteration Sheets on 10 residents weekly times 4 weeks, then monthly times 2 months. The IDT will review Admission Skin Assessments in the IDT meeting to ensure accuracy and completion of documentation, with a 2<sup>nd</sup> skin assessment completed by the Wound Care Nurse where deemed necessary. DCD's/Designee will randomly observe 10 residents, weekly times 4 weeks then monthly times 2 months to observe positioning. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee for review and further recommendations.</p>	

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F 314	<p>Continued From page 27</p> <p>dated 3/2/15 and timed 2:22 PM, stated "Excoriated area on right buttock no (sic) resolving and increase in size (0.6x0.8cm), new order received from MD to apply Medihoney hydrocolloid every three (3) days...treatment administered as ordered." A physician's order, dated 3/2/15 stated, "Cleanse open area on right buttock with NSS, apply Medihoney hydrocolloid every day shift every 3 days." This order was transcribed onto R18's TAR.</p> <p>Review of the TAR revealed the right buttock treatment was signed off as completed on 3/6/15, four (4) days after the initial treatment on 3/2/15, instead of three (3) days as ordered. The treatment failed to be signed off for 3/9/15 and was not signed off until 3/12/15, resulting in a total of five (5) days between treatments. Review of progress notes revealed no mention of the right buttock area during this time frame. The EMR lacked evidence that treatments were completed as ordered.</p> <p>The next Skin Alteration Record was dated 3/18/15 and noted a size of 0.5 cm x 0.5 cm with a scant amount of clear serous drainage and the skin surrounding the alteration was "firm/hard." However, this document failed to identify what area was being assessed. Additionally, there was no evidence that the physician and/or WCN were notified regarding the changes of the area. There was no evidence that a Skin Alteration Record was completed between 3/2/15 and 3/18/15 a 16 day time frame.</p> <p>Review of the TAR revealed the right buttock treatment was signed off completed as ordered from 3/12/15 through 3/21/15. On 3/24/15 the treatment was not signed off as completed. The</p>	F 314	<p>A. Resident R 18 currently has treatments applied as ordered and documented.</p> <p>B. Administrative Director of Nursing service/ designee will review treatment administration records of current patients to determine that application treatments are documented as ordered.</p> <p>C. The facility failed to ensure that treatment was documented as ordered on 2 occasions. Staff Development coordinator /designee will in-service licensed nurses on procedure for proper documentation on treatment administration record.</p>	

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F 314	<p>Continued From page 28</p> <p>next treatment signed off as completed was on 3/27/15, resulting in a total of five (5) days between treatments. The facility failed to consistently complete wound treatments as ordered.</p> <p>The next Skin Alteration Record (same document used for the 3/18/15 weekly assessment that failed to identify the area being assessed), dated 4/8/15, noted a size of 2 cm x 2 cm with reddened skin surrounding the alteration. There was no evidence that the skin alteration on the right buttock had been assessed for three (3) weeks from 3/18/15 through 4/8/15. Review of progress notes from 3/18/15 through 4/7/15 lacked any mention of the right buttock skin alteration.</p> <p>A Skin progress note (Late Entry), dated 4/8/15 and timed 5:00 PM, stated "Open area on right buttock measures 4.6 x 2.8 cm. Tissue type is 40% granulation, 50% dark yellow slough, 10% necrotic. Wound is moist with drainage that is light blue green. Discussed with (name of physician) new treatment order given."</p> <p>Although a Skin Alteration Record was completed on 4/8/15 (did not identify area being assessed), it did not match the findings listed in the 4/8/15 progress note regarding the right buttock area. This record stated the size was 2cm x 2 cm, pale pink tissue, no drainage, and surrounding skin reddened. Additionally, on 4/8/15 the facility began to utilize the PUSH Tool, signifying that the right buttock wound was now being classified as a pressure ulcer. The PUSH Tool score on 4/8/15 was equal to 15. The discrepancy between the two (2) assessment tools completed on 4/8/15 by different staff leads to concerns regarding accuracy and validity of the assessments prior to</p>	F 314	<p><b>D. DCD/Designee will audit for missing documentation On Treatment administration record randomly for 10 patients weekly for 4 weeks then monthly for 2 months.</b></p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>086028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - WILMINGTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 FOULK ROAD WILMINGTON, DE 19803</b>	
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F 314	<p>Continued From page 29 4/8/15.</p> <p>The new treatment order, dated 4/10/15, stated "Cleanse open area right buttock with NSS apply Meglisorb AG cover with foam and Tegaderm roll, Change QOD one time a day every other day for wound." Review of the electronic TAR revealed treatments were signed off as completed on 4/10/15, 4/12/15 and 4/13/15.</p> <p>Review of care plan #1, initiated 1/30/15, revealed that on 4/14/15, the facility included the intervention "pressure redistributing device on bed/chair." The facility failed to include this intervention initially on the 1/30/15 plan of care.</p> <p>On 4/14/15, care plan #2 was initiated for "open wound at right posterior hip related to: impaired mobility with new interventions added such as "Special mattress/cushion on bed/wheelchair (specify location); Report evidence of infections such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn." This care plan failed to identify the type of wound the open area was, such as pressure ulcer, nor did it identify the stage of the wound.</p> <p>According to the facility Skin Practice Guide, the presence of a pressure ulcer required daily body audits by a licensed nurse. Review of the electronic TAR revealed that the weekly body audit was completed on 4/9/15, however there were no daily body audits completed from 4/10/15 through 4/13/15.</p> <p>Review of the EMR revealed the following sequence of events: 4/15/15 3:58 PM - Skin note stated, "Wound rounds completed...open area to right posterior</p>	F 314	<p>A. R 18 has been screened by occupational therapy related to positioning of wheel chair, specifically related to leaning and shifting in her wheel chair. Staff is repositioning patient per patient's plan of care. Staff has been educated regarding positioning of patients.</p> <p>B. ADNS/ Designee will identify residents currently residing in the facility who are frail, are advanced age, and whose skin is already compromised have the potential to be impacted.</p> <p>C. Education will be provided to licensed nursing staff and CNA'S regarding repositioning of patients while out of bed and to identify at risk patients and to report any changes with repositioning needs. Patients at risk will have repositioning/ turning and repositioning placed on the kardex. An OT screen for positioning will be performed as appropriate. ADNS/ Staff development/designee.</p>	

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F 314	<p>Continued From page 30</p> <p>hip measuring 4.4 x 2.0 cm in size...wound bed is 90% slough and 10% red and granular...scant amount of serous drainage is noted. MD notified and treatment changed...PUSH has decreased to 13."</p> <p>4/17/15 11:47 AM - physician's order "Cleanse area right posterior hip with saline, apply Medihoney hydrocolloid, foam, and secure with transparent dressing every 3 days and PRN as needed for dislodgement."</p> <p>4/22/15 8:02 PM - Skin note stated, "Wound rounds completed...ulcer to right posterior hip...measures 3.5 x 2 cm in size...wound bed is 100% slough...area is unstageable. Reviewed with physician during rounds." The PUSH score was 11 on 4/22/15.</p> <p>During an interview with E3 (WCN) on 4/24/15 at approximately 11:00 AM, she stated that she was not aware of R18's wound since she was not informed about it. Her role as WCN was to treat open wounds/Pressure Ulcers and the staff treats all other skin alterations. E3 stated it was 4/13/15 when she was asked to assess R18's wound. She stated, that staff were doing the treatment previously, treating it as an excoriation.</p> <p>Review of the facility's "Skin Practice Guide" under Medical Care Initiative it stated "Patients admitted with skin alterations are ideally evaluated by a qualified health profession (physician...or a certified wound specialist) within 24 hours or as soon as practicable, after admission or new skin alteration identification." It is unclear why the facility failed to refer R18 to the WCN when the areas of excoriation continued to increase in size.</p> <p>The following observations were made of R18's</p>	F 314	<p>D. DCD/ADNS/designee will randomly audit 5 at risk patients for appropriate positioning weekly for 4 weeks then monthly for 2 months to ensure proper positioning of patients seating. ADNS/Designee will randomly audit 5 CNA's weekly for 4 weeks then monthly for 2 months to determine understanding of repositioning needs and use of kardex.</p>	

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F 314	<p>Continued From page 31</p> <p>turning and positioning: 4/27/15 R18 was observed in bed and was laying on her right side from 10:30 AM until 12:00 PM. At 1:00 PM, R18 was seated in a wheelchair in the lounge area with a family member. R18 was observed to be leaning more on the right side of the hip. Her left outer knee was pressed against the right inner knee, causing her weight to be shifted onto the right hip (close to the site of the wound) while sitting in the chair.</p> <p>4/28/15 was seated in a wheelchair at around 12:00 PM to 2:00 PM, R18 remained in the same position with her weight shifted onto her right side. Position was not observed to be changed.</p> <p>4/29/15 remained seated in wheelchair from approximately 11:30 AM to 2:00 PM. Position was not observed to be changed.</p> <p>In an interview with E9 (CNA) on 4/29/15 at approximately 2:00 PM, she stated that she was not aware that R18's position needed to be shifted when she was seated in a wheelchair. E9 stated that she did not shift R18's position when she was seated in the wheelchair.</p> <p>On 4/29/15 at 9:00 AM, observation of R18's wound treatment by E3 was completed. The pressure ulcer was located on the upper right buttock (on bony prominence). The wound bed was observed with slough and a necrotic area.</p> <p>On 5/6/15, E3 completed her wound rounds and at around 11:00 AM handed this surveyor a note with current measurements and description of R18's right buttock pressure ulcer. The note stated the wound measured 3.4 cm x 1.8 cm with 100% slough, with granulation at periulcer</p>	F 314		

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F 314	Continued From page 32 (around), and scant serous drainage.  The facility failed to ensure that R18, who developed a pressure ulcer, received the necessary treatment and services in accordance with the plan of care including treatments that were provided at the ordered frequency. This finding was discussed with E2 (DON) and E7 (Corporate Nurse) on 4/30/15 at 9:10 AM.	F 314		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on resident interviews, review of Resident Council Meeting minutes, and two out of two test tray results, it was determined that the facility failed to provide food that was palatable and at the proper temperature. Additionally, seven (7) out of 19 Stage 1 residents, who chose to remain anonymous, stated that the food was either cold and/or unpalatable. Findings include:  Review of the facility policy entitled, "Food Temperature at Point of Service," dated September 2014, stated "... Each patient receives and the facility provides: (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature...Food should be palatable, attractive and at the proper	F 364	<b>F364 – NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</b>  A. No Resident was identified as being impacted.  B. All Residents have the potential to be impacted if meals are found to be non-palatable.  C. The pureed food tested during survey was found to be unpalatable based on the surveyor standards. The Food Service Director may have not seasoned the pureed diet to the taste of the surveyor tasting the pureed diet on that particular day. The Food Service Director will continue to follow facility recipes and guidelines for	

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F 364	Continued From page 33 temperature as determined by the type of food to ensure patient's satisfaction...Is food served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the patient and customary practice?..."  1. Review of the Resident Council Meeting Minutes revealed the following: - In October 2014, concern regarding ice cream sometimes already melted on tray;  - In November 2014 and December 2014, concern that hot food and/or beverages were still not always hot enough.  - In January 2015 and February 2015, concern that the soup was cold.  2. On 04/27/2015 at 11:49 AM, the food cart was delivered to Heritage Hall. On 4/27/2015 at 12:25 PM, after all the residents on Heritage Hall received their trays and began eating, the food temperatures were taken by E6 (FSD) as follows: lemon baked fish - 126 degrees Fahrenheit (° F); buttered noodles - 125.6° F; lima beans - 112.8° F; coffee - 122.1° F; milk - 56.6° F; cranberry juice 58.1° F. The fish had no taste of lemon, the noodles and the lima beans were unseasoned. The food was found to be bland and unpalatable. Findings were reviewed with E1 (NHA) on 5/8/15 at approximately 12:10 PM.  2. On 4/27/15 a test tray for palatability and temperatures was completed on the New Castle hall during the midday meal. At 11:35 AM the meal cart arrived on the unit. At 11:50 AM, after the last resident was served and eating, the test tray was removed from the meal cart.	F 364	preparing meals. The Staff Development Coordinator/Designee will inservice the Food Service Director and Cooks on the Food Tasting section of the Dietary Procedures Manual outlining that food should be tasted prior to serving to check quality, taste, seasoning, texture and appearance. Additionally, a Food Quality Committee will be established for taste testing of resident meals, to include pureed diets.  D. The Food Quality Committee will test meals trays to include pureed foods daily times 12 weeks to ensure palatability. The Administrator/Designee will interview one patient per unit daily times 12 weeks to ensure palatability of meals served. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee for review and further recommendations.	

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F 364	Continued From page 34 Temperatures were obtained by E6 using the facility thermometer.  The following temperatures were obtained on the pureed foods and thickened liquids: Pureed green vegetable=150 degrees Fahrenheit (F); Pureed fish=147 degrees F; Pureed white food item=150 degrees F; Pudding=56.4 degrees F; Thickened milk=55 degrees F; Thickened water=49 degrees F; Thickened juice=50.9 degrees F.  Upon sampling the test tray the following was found: - fish was bland and had no seasoning, <del>not</del> evidence of any lemon flavor; - white food item was thought to be potatoes (as E6 stated it was) and had no flavor; later it was found to be buttered noodles; - pudding was warm and unpalatable; - thickened milk was warm, unpalatable and did not taste like milk; - thickened juice was warm and tasted watered down.  Findings were reviewed with E6 immediately after taste testing of the pureed meal and thickened fluids was completed. Review of the menu revealed the food items served were lemon fish, buttered noodles, and lima beans.  Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E7 (Corporate Nurse), and E8 (Regional Director) on 5/6/15 at approximately 12:15 PM.	F 364		
F 460	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL	F 460		

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F 460 SS=D	Continued From page 35 <b>VISUAL PRIVACY</b>  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.  This REQUIREMENT is not met as evidenced by: Based on observations in resident rooms during Stage I of the survey and family interview, it was determined that the facility failed to assure that full visual privacy was maintained for 3 (R78, R122, R167) out of 40 Stage 1 residents sampled. The facility failed to ensure that privacy curtains extended all the way around resident's beds. Findings include:  1. On 4/22/15 at 2:39 PM, during R78's room inspection, the privacy curtain was not able to be pulled all of the way around the bed to ensure full visual privacy of the resident. The curtain track also had missing hooks causing it to jam. R78's family confirmed the findings and stated it always jammed and never went all the way around.  2. On 4/23/15 at 2:45 PM, the privacy curtain in room 132 was observed off the track in several areas causing it not to close fully and thus failing to ensure full privacy for the resident (R122).  3. On 4/23/15 at 1:43 PM, R167's privacy curtain in Room 107A was difficult to pull around due to three (3) missing hooks, failing to ensure full	F 460	<b>F460 – BEDROOMS ASSURE FULL VISUAL PRIVACY</b>  A. Privacy Curtains for R78, R122, and R167 have been corrected to ensure full privacy.  B. The Maintenance Director will audit all resident rooms to ensure that Privacy Curtains are in correct working order.  C. Issues with privacy curtains identified during the survey had not yet been brought to the attention of the Maintenance Director or Housekeeping Manager. Sometimes, hooks may come undone from the privacy curtains, but are corrected by Maintenance or Housekeeping. The Staff Development Coordinator /Designee will re-in-service the Maintenance Director and Housekeeping Manager regarding facility rounds for identification privacy	

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F 460	Continued From page 36 privacy of the resident.  During the exit conference on 5/6/15 at approximately 12:00 PM, the above findings were attempted to be reviewed. E1 (NHA) stated he already heard the findings during the environmental tour conducted by another surveyor on 4/27/15.	F 460	curtain maintenance. Additionally, the Maintenance Director and Housekeeping Manager will utilize Daily Room Rounds Audit Tools for tracking necessary repairs to privacy curtains.  D. The Maintenance Director and Housekeeping Manager / Designees will complete Daily Room Rounds Audit Tools for one room on each unit daily to identify any issues with privacy curtains not completely providing necessary privacy for 12 weeks. The Administrator/Designee will randomly audit one Daily Rounds Audit Tool weekly to ensure that privacy curtain issues identified have been corrected for 12 weeks. The results of the audits will be forwarded to the Quality Assurance and Improvement Committee (QAPI) for review and further recommendations.	
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**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 677-6661

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Wilmington

DATE SURVEY COMPLETED: May 6, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>11</p> <p>3201.1.0</p> <p>3201.1.2</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 April 22, 2015 through May 6, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 129. The stage two survey sample totaled 30.</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>	<p>PLEASE CROSS REFERENCE FEDERAL POC FOR SURVEY ENDING 5/6/2015 FOR FTAGS F225, F248, F253, F256, F272, F282, F309, F314, F364, AND F460.</p>	<p>6/24/15</p>

Provider's Signature Richard [Signature] Title Admin Date 6/12/15



**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:** Manor Care Health Services Wilmington

**DATE SURVEY COMPLETED:** May 6, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p><b>This requirement is not met as evidenced by:</b> Cross refer to the CMS 2567-L survey date completed May 6, 2015 -- F225, F248, F253, F256, F272, F282, F309, F314, F364, and F460.</p>		
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Provider's Signature Robert J. [Signature] Title Admin Date 05/14/15