

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

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803	
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from June 2, 2016 through June 9, 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 110. The Stage 2 survey sample size was 42.</p> <p>Abbreviations / definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; RD - Registered Dietitian; UM- Unit Manager; WCN - Wound Care Nurse; FMD- Facility Maintenance Director; DH - Director of Housekeeping; ABI - Ankle Brachial Index/evaluates arterial blood flow by comparing pressures in the lower leg with pressures in the upper arm/used to determine circulatory status in the lower extremities; AC - Air conditioning; ADLs - Activities of Daily Living/includes bed mobility, transfer, walk in room/corridor, locomotion on/off unit, dressing, eating, toilet use, personal hygiene, and bathing; AIMS - Abnormal Involuntary Movement Scale/rating scale used to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; APM - Alternating Pressure Mattress;</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

07/05/2016

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 Analgesics-a medication that reduces pain; BID - twice a day; b/l - bilateral/both sides; BM - bowel movement; CAA - Care Area Summary/part of the MDS assessment which assists in identifying and planning for potential problem care areas; cc - cubic centimeter/unit of volume; cm - centimeter/unit of length; CVA/cva - Cerebral vascular Accident/stroke; Cognitive-memory, thinking; D/C - discontinue; DM - Diabetes Mellitus/disease in which body is unable to regulate elevated blood sugar levels; Exudate-fluid that has seeped out of a vessel or organ; EMAR - Electronic Medication Administration Record/computer documented list of daily medications to be administered; ETAR - Electronic Treatment Administration Record/computer documented list of daily treatments; Float heels-resident's heel should be protected in such a way as to remove all contact; IDT - Interdisciplinary Team/professionals from different fields and departments who work together with the resident to develop and implement an individualized plan of care; MDS - Minimum Data Set/standardized assessment forms used in nursing homes; mg- milligram/unit of weight; ml - milliliter/unit of volume; MAR-medication administration record; Metoprolol-medication that affects the heart and circulation. Can be used to treat high blood pressure. PEG/Peg - Percutaneous Endoscopic Gastrostomy/feeding tube [G-tube] inserted through abdomen into the stomach to provide	F 000			

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F 000	Continued From page 2 nourishment; PCC - Point Click Care/electronic documentation system; PRN/prn - as needed; PT - Physical Therapy; pre-before; post-after; Pt - patient; PU - pressure ulcer/sore area of skin that develops when the blood supply to it is cut off due to pressure; TID - three times a day; w/c - wheelchair; Achilles - tendon that attaches calf muscles to the heel bone; Albumin - blood test value that when decreased may occur when the body does not get or absorb enough nutrients; Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Body audit - head to toe skin assessment to identify the presence of PUs or other skin issues; cm (centimeters) - measurement of length, width and depth; Braden Scale - clinically validated tool used to identify potential levels of risk for pressure ulcer development. A score of 15-11 means the resident is at high risk for developing a PU; Enteral (feeding) tube or G-tube (GT) - tube used to feed resident directly into the stomach and/or to administer medications;	F 000			

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F 000	Continued From page 3 Eval -evaluate; Hematological - study of blood in health and disease; Hospice - end of life care/services; Kardex - CNA plan of care for individual residents; Lateral - relative to the side; Loratadine- antihistamine medication used to treat allergies; Medial - relating to the middle or center; Prevalon boots - soft boot that lifts the heel off the mattress; Promod - protein supplement; Sacrum/sacral - large triangular bone at base of spine; Slough - yellow, tan, gray, green or brown dead tissue; Stage - categorization system used to describe the severity of PUs; Thalamic infarcts - a stroke in a deep area of the brain; Ultrasound - type of imaging that uses high-frequency sound waves to look at organs and structures inside the body; 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 (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Vitamin D deficiency- low blood level of vitamin D which is essential for strong bones.	F 000			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		7/25/16	

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F 241	<p>Continued From page 4 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to promote care for 16 out of 42 Stage 2 sampled residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality during dining observations. For two residents (R27 and R155), the facility staff remained standing while feeding each resident. For 14 residents (R6, R32, R40, R53, R73, R85, R104, R141, R149, R192, R207, R271, R278 and R298), the facility served beverages in disposable plastic cups during breakfast and lunch in five (5) different locations. Findings include:</p> <p>1. During a dining observation on 6/2/16 in the Arcadia small dining room, the following observations were made:</p> <ul style="list-style-type: none"> - at 12:07 PM, E9 (RN) was observed feeding R27 from a standing position until E10 (CNA) arrived, sat down, and continued feeding R27. - at 12:20 PM, E2 (DON) was observed standing next to R155 and feeding him. At 12:30 PM, E10 (CNA) was observed feeding R155 from a standing position. <p>2. During meal observations in five (5) different locations, the following residents were served beverages in disposable plastic cups:</p> <ul style="list-style-type: none"> - on 6/2/16 at 12:07 PM in the Arcadia small dining room, R32, R40, R53, R104 and R298 	F 241	<p>A. In order to protect residents in similar situations, the facility is no longer using plastic cups for additional liquids during meal service.</p> <p>In order to protect residents in similar situations, there are sufficient chairs available for staff to be seated while feeding residents. Staff are not standing when feeding residents and additional chairs have been ordered and we are waiting for their arrival.</p> <p>B. Residents residing in facility would have the ability to be impacted by this deficient practice.</p> <p>The DON/Designee will evaluate each dining area to determine if there is enough seating available so that staff are able to be seated while assisting residents eating.</p> <p>The Dietary Manager/Designee will evaluate existing stock of tumblers and order additional tumblers in order to have tumblers available during dining service so that plastic cups are not used during dining service.</p> <p>Unit Managers/Designee will do daily observational audits of meals in the dining rooms to ensure that residents do not have plastic cups and that staff are not standing while feeding a resident.</p>	

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F 241	<p>Continued From page 5</p> <p>were served beverages in disposable plastic cups.</p> <ul style="list-style-type: none"> - on 6/2/16 at 12:31 PM in the New Castle dining room, R149 was served a beverage in a disposable plastic cup. - on 6/2/16 from 12:35 PM to 12:54 PM in the Arcadia large dining room, R85, R192, R207, R271 and R278 were served beverages in disposable plastic cups. - on 6/2/16 at approximately 12:54 PM, R6 was served a beverage in a plastic disposable cup with his breakfast meal tray in his room on the Arcadia hallway. - on 6/3/16 at 8:27 AM in the Arcadia large dining room, R40, R53, R141 and R278 were served beverages in disposable plastic cups. - on 6/6/16 at 7:58 AM, R73 was served a beverage in a plastic disposable cup with her breakfast meal tray in her room on the New Castle hallway. <p>Findings were reviewed on 6/9/16 at 1:40 PM with E2 (DON). The facility failed to ensure residents were treated in a dignified manner.</p>	F 241	<p>C. The small dining room on Arcadia required additional chairs on the day that staff were observed standing while assisting residents with feeding and extra tumblers were not available for additional liquids during meal service.</p> <p>Detailed below and in Section D. are the measures the facility will take and system changes to ensure the problem does not recur.</p> <p>Dietary will send extra tumblers to each dining room during meal service and plastic cups will not be sent to the dining room for beverages during meal service.</p> <p>Unit Managers/Designee will ensure that sufficient seating is available in dining areas and if it is determined that additional chairs are necessary, additional chairs will be brought to the dining room before meal service begins.</p> <p>Additional tumblers and chairs will be purchased.</p> <p>The Staff Development Coordinator/Designee will educate licensed nursing staff and C.N.A.s on requirements of sitting while feeding a resident.</p> <p>The Staff Development Coordinator/Designee will educate licensed nursing staff and C.N.A.s on ensuring extra fluids provided to residents during meal service are done so in hard</p>		

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F 241	Continued From page 6	F 241	<p>plastic tumblers sent up from the kitchen.</p> <p>D. The Staff educator/designee will audit meal service daily x 2 weeks, then weekly x 2 weeks, then monthly x2 to validate that licensed nursing staff and C.N.A.s are seated while feeding residents.</p> <p>The Staff educator/designee will audit meal service in dining rooms to validate that extra beverages provided to residents are done so in aplastic tumblers from the kitchen, this will be done daily x 2 weeks, weekly x 2 weeks, then monthly x 4.</p> <p>Dietary Services/designee will validate that each dining room is provided with extra tumblers during meal service weekly x4, then monthly x 2.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p>	F 246		7/25/16

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F 246	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that all call lights were within reach for one resident (R11) who was capable of using it. Finding include:</p> <p>The following was found during the stage 2 environmental tour on 6/6/16 from 12:30 PM and 2:00 PM:</p> <p>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.</p> <p>Findings were reviewed and confirmed by E1 (NHA), E5 (FMD), and E11 (DH) at approximately 1:45 PM.</p>	F 246	<p>A. R11's call bell in the bathroom is no longer wrapped around the grab bar in the bathroom. In order to protect other residents in similar situations, the facility will thoroughly audit resident rooms to ensure that call bells are not wrapped around grab bars.</p> <p>B. The DON/Designee audited resident rooms to ensure that call bells are not wrapped around grab bars and any call bells that are found wrapped around grab bars will be corrected immediately.</p> <p>Residents residing in the facility have the ability to be impacted by this deficient practice and should have call bells in reach.</p> <p>C. It is the practice of the facility to provide reasonable accommodations of needs/preferences. A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preference except when the health or safety of the individual or other residents would be endangered.</p> <p>One call bell was noted to be wrapped around a grab bar in a resident's bathroom and that is not the facility practice.</p> <p>Detailed below are the measures and system changes that the facility will follow to ensure that the problem does not recur.</p>		

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F 246	Continued From page 8	F 246	<p>The Staff Development Coordinator/Designee will in-service staff that call bells are not wrapped around grab bars.</p> <p>D. The DON/Designee will perform a random audit of 10 patients rooms to validate that call bells are not wrapped around grab bars daily x 2 weeks, then weekly for 2 weeks, then if appropriate monthly times 2 months.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on 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 25 rooms (Room 100, 103, 104, 107, 108, 109, 110, 111, 114, 116, 120, 121, 128, 131, 133, 135, 136, 140, 228, 232, 234, 236, 237, 239, and 241) out of 34 rooms, both Arcadia dining units, Arcadia hallway, New Castle hallway and the New Castle small lounge.</p>	F 253	<p>A. Issues identified in Room 100, 103, 104, 107, 108, 109, 110, 111, 114, 116, 120, 121, 121, 128, 131, 133, 135, 136, 140, 228, 232, 234, 236, 237, 239, 241, both Arcadia dining units, Arcadia hallway, New Castle hallway, and New Castle small lounge have been repaired/corrected.</p> <p>In order to protect residents in similar</p>	7/25/16	

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F 253	<p>Continued From page 9</p> <p>Findings include:</p> <p>The following was found during the environmental tour on 6/6/16 from 10:15 AM to 11:00 AM as well as during stage 1:</p> <p>6/2/16 11:32 AM - Small Dining Room in Arcadia</p> <ol style="list-style-type: none"> 1. The outer trim holding the ceiling tile was rusty; 2. The wallpaper in the room was peeling; 3. The wall molding was peeling by the bathroom door; 4. A pipe was protruding from the wall by the sink; 5. The exterior of the refrigerator was dirty; 6. The cabinet bottom right side of the sink was missing a handle; 7. A cobweb was observed in the small window above the door to the patio; 8. The door frame for the door to the outside patio had chipped paint; 9. The lock on the door knob was removed, exposing the interior of the lock; 10. The dining table was dirty; 11. The sink was dirty around the faucet; 12. The bathroom door was chipped and scratched; 13. The bathroom toilet was running; 14. The wall by the window had chipped paint and peeling wallpaper; 15. The toilet in the lounge was running; 16. The bathroom had an unpainted patch on the wall to the left of the sink; 17. The light over the sink had a broken cover; 18. The bathroom door frame had chipped paint. <p>6/2/16 11:32 - Main Arcadia Dining Room</p> <ol style="list-style-type: none"> 1. There was torn wallpaper above the door entry; 2. The edges of the wall had torn wallpaper; 	F 253	<p>situations, the facility will continue with environmental rounds. Additionally, the Arcadia Small Dining Room, Arcadia Large Dining Room, and Arcadia Lounge have received a renovation. The facility is also in the process of renovating Arcadia resident room bathrooms.</p> <p>B. The Maintenance Director/Housekeeping Manager will complete weekly environmental rounds to evaluate whether the facility is maintaining a sanitary, orderly and comfortable interior. Any findings will be addressed as residents residing in the facility have the ability to be impacted.</p> <p>C. The issues identified during the annual survey had not been identified through rounds as requiring attention.</p> <p>Detailed below is the system changes and monitoring the facility will do in order to ensure that the problem does not recur and that solutions are sustained.</p> <p>It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.</p> <p>The Maintenance Director and/or designee will perform random weekly audits using the environmental checklist to evaluate compliance to address any environmental findings.</p> <p>The Staff Development Coordinator/Designee will in-service staff</p>	

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F 253	<p>Continued From page 10</p> <p>3. The wall to the left of the poster of cars was in disrepair;</p> <p>4. The wall board and floor between the brown armoire and the dry erase board had no molding at the bottom;</p> <p>5. The lower corner wall under the TV screen had an unpainted area;</p> <p>6. A section of wallpaper was missing under the windowsill next to the TV;</p> <p>7. There were 2 stained ceiling tiles above the entry door;</p> <p>8. The baseboard was missing to the left of the window.</p> <p>6/2/16 12:00 PM - New Castle Small Lounge</p> <p>1. The piano chair had scratches all over and was not sturdy;</p> <p>2. The hallway had multiple chipped doorway frames;</p> <p>3. The hallway had chipped and peeling wallpaper;</p> <p>4. The windows at the end of the hallway were dirty;</p> <p>5. The emergency electrical outlet between rooms 135 and 137 was in disrepair.</p> <p>6/3/16 at 11:00 AM - Arcadia Hallway</p> <p>1. The hallway carpet had stains in multiple areas;</p> <p>2. Four [4] ceiling vents along the hallway had multiple areas of black discoloration.</p> <p>The following were found during the environmental tour on 6/6/16 from 12:30 PM to 2:00 PM:</p> <p>Room 100</p>	F 253	<p>on identifying and communicating environmental findings through the maintenance TELs or 24 hour report.</p> <p>D. The Maintenance Director/Designee will perform random environmental audits on one room daily for one week, then 10 rooms weekly for 11 weeks using the environmental checklist to evaluate compliance and address any environmental findings. The monitored areas will include all areas cited in the report in addition to other areas throughout the facility.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>	

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F 253	<p>Continued From page 11</p> <ul style="list-style-type: none"> - The bathroom door frame and the wall next to it were in disrepair; - The bathroom sink had chipped ceramic on the right side; - The sink edging was chipped; - The toilet caulking was discolored; <p>Room 103</p> <ul style="list-style-type: none"> - The wall along the bottom near the bathroom was scraped; - The entry doorframe was scraped; <p>Room 104</p> <ul style="list-style-type: none"> - The closet area to the left of the bed had missing tile with exposed concrete floor; <p>Room 107</p> <ul style="list-style-type: none"> - The entry doorframe along the edge was chipped; - The bathroom doorframe on the right side was scraped; - The bathroom sink was dirty; - The sink's caulking along the wall was in disrepair; <p>Room 108</p> <ul style="list-style-type: none"> - AC unit vent was dirty; - There was an unpainted plastered area to the right of the AC unit; - The entry doorframe edges were chipped; - The wallpaper was scraped to the right of the window; - The bathroom counter was dirty, with peeling caulking around the sink; <p>Room 109</p> <ul style="list-style-type: none"> - The bathroom door was scratched on the inside; - The wallpaper was peeling above B bed; 	F 253		

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F 253	<p>Continued From page 12</p> <p>Room 110 - The lower portion of the wall around the perimeter of the room was badly scraped;</p> <p>Room 111 - The ceiling tile above B bed was stained; - The wallpaper behind A bed was torn; - The plaster repaired wall by the bathroom sink was not treated to match with the wallpaper;</p> <p>Room 114 - The bathroom light cover was cracked; - The wallpaper was ripped near the head of bed A, by the bathroom entrance, and the window;</p> <p>Room 116 - The lower floor around the perimeter of the room was very badly scraped; - The bathroom faucet was dripping water; - The toilet water tank cover did not fit the water tank;</p> <p>Room 120 - The wallpaper was peeling behind bed A; - The molding behind bed A was torn; - The bathroom and bedroom floors were dirty, especially in the corners; - The wallpaper in the bedroom was peeling on the wall in front of the bed; - The doorframes had chipped paint; - The caulking around the toilet had missing areas and was discolored; - The wallpaper in the bathroom was peeling; - The caulking around the sink was dirty; - The towel holder was loose to the left of the bathroom sink;</p> <p>Room 121 - The bathroom wall had an unpainted patch to</p>	F 253		

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F 253	Continued From page 13 the left side of sink; - The bathroom door squeaked when opened; - The bathroom door was scratched in multiple places; - The bathroom floor was dirty; - The bathroom faucet was dirty and in disrepair; - The bathroom countertop was dirty; - The wallpaper was missing in several places around the sink; - The towel holder was loose next to the sink; - The hook on back of the bathroom door was not secure; - The bathroom door frame had chipped paint; - The wallpaper in the bedroom was peeling off the wall; Room 128 - The bathroom door on the inside was severely scraped; Room 131 - The wallpaper throughout the room was peeling; Room 133 - The bathroom floor was dirty; - The bathroom door squeaked when opened and closed; Room 135 - The bathroom and bedroom floors was dirty; - The doorframes had chipped paint; - The bathroom wallpaper was peeling; - The sink faucet was dirty; - The bathroom light was missing a cover; Room 136 - The bathroom floor was dirty; - The bathroom wallpaper was peeling to the left side of the sink;	F 253			

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F 253	<p>Continued From page 14</p> <ul style="list-style-type: none"> - The caulking around the toilet was discolored and had missing sections; - The bathroom ceiling was bubbling in two areas above the toilet; - The bathroom door was chipped; - The bedroom ceiling tile was stained; <p>Room 140</p> <ul style="list-style-type: none"> - The toilet was loose; - There was no caulking around the base of the toilet; - The bathroom wallpaper was ripped in several areas; - The caulk around the tile in the bathtub was discolored; - Overbed table base was dirty; <p>Room 228</p> <ul style="list-style-type: none"> - The bathroom towel rack near the paper towel dispenser was in disrepair; <p>Room 232</p> <ul style="list-style-type: none"> - There were missing areas of paint on the wall above the heater; <p>Room 234</p> <ul style="list-style-type: none"> - The handle on the bathroom door was loose; <p>Room 236</p> <ul style="list-style-type: none"> - The bathroom sink was stained; - The bathroom faucet had oxidized and rusted areas; <p>Room 237</p> <ul style="list-style-type: none"> - The right side wall at the entrance had peeling wallpaper and scuff marks near the bottom of the wall; <p>Room 239</p>	F 253		

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F 253	Continued From page 15 - There were 2 holes in the wall in the bathroom on the left side by the entrance; - The grab bar above the toilet was rusty; Room 241 - The bathroom wall had scrapes. The facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly interior. This failure affected 25 rooms, both dining rooms, two hallways, one lounge area posing a potential for harm to the residents due to the unsanitary conditions. During an interview findings were reviewed and confirmed by E1 (NHA), E5 (FMD), and E11 (DH) on 6/6/16 at approximately 1:45 PM.	F 253		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide comfortable lighting for 2 rooms (108 and 236) out of 34 rooms. Findings include: The following were found during the environmental tour on 6/6/16 from 12:30 PM to 2:00 PM: Room 108 A bed - The overbed light only had one working setting;	F 256	A. Room 108A Bed Over bed Light was repaired. Room 236A Bed Over bed light was repaired. In order to protect residents in similar situations, resident rooms will be audited to ensure that over bed lights are functioning appropriately and have operational light bulbs. B. Maintenance Director/Designee audited resident rooms to ensure that over bed lights are functioning appropriately and have operational light	7/25/16

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F 256	Continued From page 16 Room 236 A bed - There were no bulbs in the light fixture. During an interview findings were reviewed and confirmed by E1 (NHA), E5 (FMD) and E11 (DH) on 6/6/16 at approximately 1:45 PM.	F 256	<p>bulbs as residents residing in the facility have the ability to be impacted. Non-functioning lights identified will be repaired/corrected as necessary</p> <p>C. Room 108A and 236A had not been identified that lights were not functioning properly and that light bulbs were missing.</p> <p>Detailed below is the measures the facility will take and the systems it will alter to ensure the problem does not recur.</p> <p>It is the practice of this facility to provide adequate and comfortable lighting in all areas and when a light no longer operates appropriate, the facility will make corrections through replacement of light bulbs or replacements of light fixtures.</p> <p>The Maintenance Director and/or designee will perform random weekly audits using the environmental checklist which includes testing over bed lights for functionality.</p> <p>Additional over bed lights have been purchased.</p> <p>The Staff Development Coordinator/Designee will in-service staff to report any issues with over bed lights through TELs or on the 24 hour report.</p> <p>D. The Maintenance Director/Designee will conduct a random audit of one resident room to ensure over bed lights are operating appropriately daily for one week, then weekly for 3 weeks, then if</p>	

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F 256	Continued From page 17	F 256	appropriate monthly time 2 months.		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop comprehensive care plans for two (R42 and R53)</p>	F 279	<p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p> <p>1. R42 A. R42 now has a care plan for Hospice</p>	7/25/16	

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F 279	<p>Continued From page 18 out of 42 stage 2 sampled residents. Findings include:</p> <p>1. R53 had a care plan written on 6/30/15 for a hematological condition related to anemia and a vitamin D deficiency. Although the care plan was reviewed by the facility every 3 months since it was initiated, the facility failed to identify that vitamin B was associated with R53's anemia, not vitamin D.</p> <p>Findings were confirmed during an interview with E2 (DON) on 6/7/16 at approximately 3:40 PM.</p> <p>2. R42's clinical record revealed the resident was receiving Hospice services since approximately 6/16/2015.</p> <p>Review of the comprehensive care plan lacked evidence that a care plan was developed for the coordination of Hospice services.</p> <p>On 6/9/16 at 10:05 AM, E13 (RN) confirmed there was no Hospice care plan for R42.</p> <p>Findings were reviewed with E1(NHA) and E2 (DON) on 6/9/16 at approximately 6:00 PM during the exit conference.</p>	F 279	<p>Services. In order to protect residents in similar situations, an audit will be conducted identifying residents who are receiving Hospice Services and care plan will be reviewed.</p> <p>B. The DON/Designee performed an audit identifying residents who are receiving Hospice Services as residents who are receiving Hospice Services may be impacted.</p> <p>C. The facility failed to add a care plan for Hospice Services when R42 began Hospice Services.</p> <p>Detailed below and in section D. are the measures the facility will take and the system changes to ensure that the problem does not recur.</p> <p>The Staff Development Coordinator/Designee will educate licensed nurses that residents receiving Hospice Services require a Hospice Care Plan.</p> <p>D. The DON/Designee will validate weekly that residents residing in facility and those newly admitted and identified as receiving Hospice Services have a Hospice care plan. This audit will be weekly times 4, then monthly times 2.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will</p>	

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F 279	Continued From page 19	F 279	<p>determine need for further audits and/or action plans.</p> <p>2. R53</p> <p>A. R 53's care plan regarding hematologic condition is now corrected. In order to protect residents in similar situations, the DON/Designee will audit resident to identify residents diagnosed with a hematologic condition.</p> <p>B. The DON/Designee performed an audit identifying residents diagnosed with a hematologic condition.</p> <p>C. The facility incorrectly added Vit B to R53's care plan instead of Vit D.</p> <p>Detailed below and in Section D. are the measures the facility will take and the system changes to ensure the problem does not recur.</p> <p>The Staff Development Coordinator/Designee will educate licensed nurses that residents identified with a hematologic condition, will have interventions portion of care plan - Administer medications per physician order and refrain from picking use of Vitamin B.</p> <p>D. The DON/Designee will validate that residents residing in facility and those newly admitted with a diagnosis of a hematologic condition have intervention on care plan that states - Administer</p>		

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F 279	Continued From page 20	F 279	medications per physician orders. This audit will be weekly times 4, then monthly times 2. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.		
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, interview and review of other facility documentation it was determined that the facility failed to 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 for two (R6 and R112) out of 40 Stage 2 sampled residents. For R112, the facility failed to adequately assess the resident's pain level post administration of prn medications by not using the same pain assessment scale consistently for pre and post assessment. For R6, the facility failed to monitor and assess for constipation after the resident</p>	F 309	<p>1. R112</p> <p>A. R112 now has pain score post prn pain medication administration documented. In order to protect residents in similar situations, the DON will perform and audit to identify residents who are receiving prn pain medications.</p> <p>B. The DON/Designee will perform an audit to identify residents who are receiving prn pain medications.</p>	7/25/16	

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F 309	<p>Continued From page 21 went 3 days with no BM. Findings include:</p> <p>Pain management standards approved by the American Geriatrics Society in April 2002 included: appropriate assesment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for intial and follow up assesment; set standards for monitoring and intervene and collect data to monitor the effectiveness of pain management.</p> <p>The facility Pain Practice Guide, issued in November 2011, stated to obtain pain scores daily and before and after administration of prn analgesics. Scores are documented on the MAR.</p> <p>The facility policy entitled Medication and Treatment Administration Guidelines, dated December 2014, stated that prn pain medications require the evaluation of pain both prior to and after the administration of medications ordered for pain management.</p> <p>1. Review of R112's clinical record revealed:</p> <p>4/7/16 - Physician's order was written for prn pain medication for mild pain and a separate medication for moderate pain.</p> <p>4/8/16 - A care plan problem for pain (last revised 6/7/16) included the following interventions: administer pain medication according to physician orders.</p> <p>4/14/16 - An admission MDS assesment documented the resident as cognitively intact.</p>	F 309	<p>C. Detailed below and in Section D. are the measures the facility will take and system changes to ensure the problem does not recur.</p> <p>The Staff Development Coordinator/Designee will in-service licensed nursing staff that when administering a prn pain medication, they must put in a pain score post administration and refrain from documenting "effective".</p> <p>D. The DON/Designee will randomly audit 10 residents records to ensure that pain score was recorded post administration of pain med. This audit will be performed weekly x 4 weeks, then monthly times 2.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p> <p>2. R6</p> <p>A. The facility is ensuring that R6 is receiving ordered Bowel Protocol of MOM on 3rd day when no BM. In order to protect residents in similar situations, the DON will perform and audit to identify residents residing in facility with No BM x 3 days.</p> <p>B. The DON/Designee will perform an</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803		
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F 309	<p>Continued From page 22</p> <p>April 2016 - EMAR review found prn pain medications were administered a total of 18 times: 4/9, 4/10, 4/13, twice on 4/14, twice on 4/15, 4/17, 4/18, 4/24, 4/27, twice on 4/28, three times on 4/29, and twice on 4/30; documentation did not include a numeric pain assessment after administration.</p> <p>5/20/16 - A physicians order was written discontinuing R112's original prn pain medication for moderate pain and changing it to another.</p> <p>May 2016 - EMAR review found prn pain medications were administered a total of 59 times: single administrations on 5/8, 5/15, 5/20, 5/27 and 5/31 then twice on 5/1- 5/4, 5/6, 5/10-512, 5/16-5/17, 5/20- 22, 5/25, 5/26, and 5/29, triple administrations on 5/5, 5/13, 5/14, 5/18, 5/19, and 5/24 and four administrations on 5/23. Documentation did not include a numeric pain assessment after administration.</p> <p>June 2016 - EMAR reviewed found prn pain medications were administered a total of 3 times: 6/2, 6/5, and 6/6. Documentation did not include a numeric pain assessment after administration.</p> <p>Review of R112's progress notes from April 2016- June 2016, revealed there was no pain score after administration; post assesment was documented as "effective".</p> <p>During an interview on 6/9/16 at 9:28 AM with E6 (LPN), E6 stated that for prn medication administration, "if a resident is alert, we use the numeric scale, and we ask them to see if it (pain) has decreased or not." E6 further reported that documentation of pre and post assessment pain for prn medication administration are documented</p>	F 309	<p>audit to identify residents residing in facility with No BM x 3 days.</p> <p>C. Detailed below and in Section D. are the measures the facility will take and system changes to ensure that the problem does not recur.</p> <p>Residents having No BM in 3 days will be placed on Alert Charting. Alert report focusing on no BM x 3 days will be run daily.</p> <p>The Staff Development Coordinator/Designee will in-service licensed nursing staff on administering prn constipation meds on 3rd day and if pattern off difficulties with BM are routinely noted, notify MD for further instructions.</p> <p>D. The DON/Designee will randomly audit residents having no BM in 3 days will be placed on Alert Charting until resident has had a BM. This audit will be performed daily x 4 weeks, then weekly x 4 weeks, then monthly x 2 weeks.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>		

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F 309	<p>Continued From page 23</p> <p>"in the computer, it will give you an effective or ineffective."</p> <p>During an interview on 6/9/15 at 9:33 AM with E4 (UM), E4 stated "the post assesment tool of the facility software does not give the option to document using the numeric scale, it just gives effective or ineffective."</p> <p>The facility failed to adequately assess R112's pain following administration of prn pain medications as evidenced by failing to consistently use the same pain assesment scale pre and post assesment.</p> <p>2. The following was reviewed in R6's clinical record:</p> <p>6/20/13 - R6 admitted to the facility.</p> <p>4/7/14 - physician's order for MOM 30 ml orally as needed for constipation every 3 days.</p> <p>Review of the electronic documentation for BMs revealed the following: 5/25/16 10:55 AM through 5/30/16 7:57 AM - approximately five (5) days with no BM; 6/3/16 7:47 AM through 6/9/16 2:35 PM - approximately six (6) days with no BM. Review of the EMAR and the progress notes for the same period of time lacked evidence of administration of MOM for constipation.</p> <p>6/9/16 at 4:45 PM - During an interview with E2 (DON) findings were reviewed. E2 stated that at times it was difficult to accurately monitor R6 for BMs as he sometimes toileted himself.</p> <p>6/9/16 at approximately 6:00 PM - findings were</p>	F 309		

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F 309	Continued From page 24 reviewed with E1 (NHA) and E2 during the exit conference.	F 309		
F 314 SS=G	<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 observation, record review, interview, and review of other documents as indicated, it was determined that for two (R217 and R274) out of 42 Stage 2 sampled residents, the facility failed to provide care and services to prevent PUs from developing and failed to thoroughly assess a PU. For R217, the facility failed to ensure the resident, who entered the facility without a PU, did not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. The facility failed to: develop a specific turning and repositioning schedule for R217, who was identified at risk for developing PUs; failed to identify an area of pressure until it presented as suspected deep tissue injury (DTI); and failed to offload R217's heels in an attempt to prevent PUs from developing. For R274, the facility failed to identify her sacral PU on the 5/4/16 admission skin assessment and failed to stage her sacral PU</p>	F 314	<p>1. R217</p> <p>A. Resident #217 had her plan of care and TASK reviewed and it was determined that all appropriate interventions are in place. Further, resident is turned/repositioned frequently and Prevalon boots are applied properly on residents feet providing for offloading.</p> <p>In order to protect residents in similar situations, the facility will identify residents at risk for developing pressure ulcers and those that currently have pressure ulcers to validate that interventions in plan of care and TASK are appropriate and where applicable include offloading of heels/Prevalon Boots and turning and repositioning.</p>	7/25/16

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F 314	<p>Continued From page 25 identified on the 5/5/16 skin assessment until 5/11/16. Findings include:</p> <p>The facility's "Skin Practice Guide," issue date 01/2013, states: "...Prevention Interventions Reposition frequently in bed and chair Rehabilitation team consultations...Elevate heels Select appropriate support surfaces Complete thorough skin observations...Skin Observations Nursing assistants perform daily skin observations with routine care. The Skin Worksheet is completed by the nursing assistant at least two times per week with the patient's bath (shower, tub, bed). Results are submitted to the licensed nurse for review and follow-up as needed...Note: The Skin Worksheet is a communication tool and is not maintained as part of the clinical record...Positioning, Mobility, Restraints...elevate or "float" heels, even if patient is on specialty support surface..."</p> <p>The International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Clinical Practice Guideline, second edition published 2014, Pressure Ulcer Classification System identifies six (6) categories/stages. Two (2) of those categories/stages are: - "Unstageable: Depth Unknown - Full thickness loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. - Suspected Deep Tissue Injury (sDTI): Depth Unknown - purple or maroon localized area of discolored intact skin or blood-filled blister due to</p>	F 314	<p>B. The facility will identify residents at risk for developing pressure ulcers and those residents that currently have pressure ulcers to validate that interventions in plan of care and TASK are appropriate and where applicable include offloading of heels/Prevalon Boots and turning and repositioning.</p> <p>An Audit will be conducted on residents identified as at risk for developing pressure ulcers and those that currently have pressure ulcers to validate that the plan of care and TASK match.</p> <p>These residents identified in the above audit are at risk.</p> <p>C. Detailed below and in Section D. are the measures the facility will take and the system changes to ensure that the problem does not recur.</p> <p>The Staff Development Coordinator/Designee will re-educate Licensed Nursing staff on need to have offloading/Prevalon boots/turn and reposition on the TASK when it is contained within the resident's plan of care.</p> <p>The Staff Development Coordinator/Designee will re-educate licensed nursing staff on need for plan of care and the TASK to match.</p> <p>The Staff Development Coordinator/Designee will re-educate licensed nursing staff and C.N.A. on need</p>		

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F 314	Continued From page 26 damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue...Pressure Ulcer Assessment...3. Assess and document physical characteristics including: location, category/Stage, size, tissue type (s), color...exudate, and odor...General Repositioning for All Individuals 1. Reposition all individuals at risk of, or with existing pressure ulcers, unless contra-indicated...Repositioning Frequency 1. Consider the pressure redistribution support surface in use when determining the frequency of repositioning...2. Determine repositioning frequency with consideration to the individual's tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort...3. Establish pressure relief schedules that prescribe the frequency and duration of weight shifts...4. Regularly assess the individual's skin condition and general comfort...Frequent assessment of the individual's skin condition will help to identify the early signs of pressure damage and, as such, her/his tolerance of the planned repositioning schedule. If changes in skin condition should occur, the repositioning care plan needs to be re-evaluated...Repositioning To Prevent And Treat heel Pressure Ulcers...The posterior prominence of the heel sustains intense pressure, even when a pressure redistribution surface is used. General Recommendations 1. Inspect the skin of the heels regularly...Repositioning for Preventing Heel Pressure Ulcers 1. Ensure that the heels are free of the surface of the bed...Ideally, heels should be free of all pressure - a state sometimes called 'floating heels'...Continue to reposition individuals placed on a pressure redistribution support surface..."	F 314	to follow the residents plan of care and TASK. D. The DON/Designee will validate that residents identified as at risk for developing pressure ulcers, and those residents that have pressure ulcers have TASKS that match the residents Plan of Care. This audit will be conducted weekly x 4 times, then monthly x 2 months. Results of the audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans. 2. R274 A. Resident # 274 no longer resides at the facility In order to protect residents in similar situations, the Licensed Nurse responsible for the admission skin evaluation and the wound care nurse that did not stage the area of pressure received 1:1 education. B. Newly admitted patients have the ability to be impacted by inaccurate Admission skin assessments. C. Detailed below are the measures the facility will take and the system changes to ensure the problem does not recur.		

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F 314	Continued From page 27 1. Review of R217's clinical record revealed the following: 12/8/15 - R217 was admitted to the facility following hospitalization for b/l thalamic infarcts. 12/9/15 3:52 AM - Braden Scale completed and identified R217 as being at moderate risk for skin breakdown. 12/9/15 4:12 AM - admission progress note states R217 is alert to self, non verbal but blinks eyes appropriately to simple questions, has a Peg tube for feeding and requires total assistance with ADLs. 12/9/15 3:47 PM - Skin progress note completed by WCN stated, "Skin assessment completed...requires total assist of staff for ADLs...An area of pink closed scarred tissue without drainage is present to the right Achilles. Bony prominences and skin folds are free of abnormality...". 12/9/15 - Care Plan developed for "At risk for alteration in skin integrity related to: incontinence, impaired mobility, cognitive loss, DM, Braden score of 11. Interventions included: "APM mattress to bed/cushion to w/c; Diet and supplements per physician order; Encourage to reposition as needed; Float heels as able; Observe skin condition with ADL care daily; report abnormalities; Prevalon boots while in bed; Use pillows/positioning devices as needed." Although an at risk for skin integrity impairment care plan was developed, the facility failed to specify the frequency of turning and repositioning.	F 314	If an alteration in skin integrity is identified on admission, a designated member of the wound team evaluates the status of the wound and will properly stage the alteration in skin integrity. The Staff Development Coordinator/Designee will re-educate licensed nursing staff on how to complete the Admission Skin Evaluation. The Staff Development Coordinator/Designee will re-educate wound care nurse/team on need to stage pressure ulcers. D. The DON/Designee will validate that residents admitted to facility have a Skin Admission evaluation and that any skin alterations in skin integrity is reviewed by a member of the wound care team to determine the type of alteration present. This audit will be conducted weekly x 4 weeks, then monthly x 2 months. The DON/Designee will validate that the wound care team is staging pressure ulcers by reviewing documentation weekly x 4 weeks, then monthly x 2 months. Results of the audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.	

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F 314	Continued From page 28 12/15/15 - The admission MDS assessment stated that during the seven (7) day review period R217: - had unclear speech; - daily decision making skills were severely impaired; - required extensive assist from two (2) staff for bed mobility and toilet use; - did not ambulate in room or corridor; - had a feeding tube that provided 51% or more of total calories received; - was at risk of developing PU, but did not currently have any PU; - had a pressure reducing device for chair/bed. The CAA portion of the 12/15/15 admission MDS assessment triggered pressure ulcer as a potential problem area. 12/25/15 - Braden Scale was completed and now identified R217 as being at high risk for development of pressure ulcers. 1/8/16 - A Body audit was signed off as completed on the ETAR. There was no evidence of any skin issues noted in the clinical record. Review of the electronic Documentation Survey Report, completed by CNAs, for repositioning and/or toileting revealed that on the following dates and times R217's repositioning exceeded three (3) hours: 1/8/16 - repositioned and/or toileted at 6:00 AM and then not until 2:57 PM, approximately nine (9) hours; 1/9/16 - repositioned and/or toileted at 2:36 AM and then not until 6:14 AM, approximately four (4) hours; 1/9/16 - repositioned and/or toileted at 11:39 AM	F 314			

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F 314	Continued From page 29 and then not until 3:45 PM, approximately four (4) hours; 1/9/16 - repositioned and/or toileted at 3:45 PM and then not until 7:39 PM, approximately four (4) hours; 1/9/16 - repositioned and/or toileted at 10:22 PM and then not until 1:15 AM on 1/10/16, approximately three (3) hours; 1/10/16 - repositioned and/or toileted at 3:55 PM and then not until 7:11 PM, approximately three (3) hours; 1/10/16 - repositioned and/or toileted at 7:11 PM and then not until 10:38 PM, approximately three (3) hours; 1/11/16 - repositioned and/or toileted at 3:10 AM and then not until 6:11 AM, approximately three (3) hours; 1/11/16 - repositioned and/or toileted at 6:11 AM and then not until 12:59 PM, approximately six and one half (6 and 1/2) hours; 1/11/16 - repositioned and/or toileted at 12:59 PM and then not until 4:25 PM, approximately three and one half (3 and 1/2) hours; 1/11/16 - repositioned and/or toileted at 4:25 PM and then not until 7:29 PM, approximately three (3) hours; 1/11/16 - repositioned and/or toileted at 7:29 PM and then not until 10:30 PM, approximately three (3) hours; 1/12/16 - repositioned and/or toileted at 12:59 AM and then not until 6:23 AM, approximately five and one half (5 and 1/2) hours; 1/12/16 - repositioned and/or toileted at 10:20 AM and then not until 1:35 PM, approximately three (3) hours; 1/12/16 - repositioned and/or toileted at 7:26 PM and then not until 12:15 AM on 1/13/16, approximately five (5) hours; 1/13/16 - repositioned and/or toileted at 12:15 AM	F 314			

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F 314	<p>Continued From page 30</p> <p>and then not until 5:32 AM, approximately five (5) hours; 1/13/16 - repositioned and/or toileted at 5:31 AM and then not until 9:32 AM, approximately four (4) hours; 1/13/16 - repositioned and/or toileted at 9:32 AM and then not until 2:59 PM, approximately five and one half (5 and 1/2) hours;</p> <p>Review of the CNA's electronic Documentation Survey Report revealed R217 had bed baths on 1/8/16 at 2:57 PM and on 1/12/16 at 2:36 PM. There was no evidence in the clinical record that any skin issues had been identified.</p> <p>1/13/16 at 4:44 PM - A progress note stated, "Patient with suspected deep tissue injury to bilateral heels. Left medial heel area of (sic) dark purple tissue that is intact skin measuring 2.2 x 2.8 cm. Right heel medial dark purple area that is dry and callused area of intact skin. Patient with recent cva. decreased mobility...Prevalon boots in place on feet, APM in place on bed, therapy eval to improve mobility. Nutrition is managed with tube feeding."</p> <p>Review of progress notes, EMARs, ETARs, and CNA Documentation Survey Reports from 12/8/15 through 1/13/16 lacked evidence of the use of Prevalon boots and/or offloading of the heels.</p> <p>According to the 12/9/15 at risk for skin impairment care plan, staff were to monitor and report any skin abnormalities. Despite this intervention, the b/l heel wounds were not identified until they were sDTI.</p> <p>1/14/16 - blood test for Albumin level was</p>	F 314		

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F 314	<p>Continued From page 31 completed and results were within normal range.</p> <p>1/15/16 - The Kardex Task History has entry "Prevalon boots, remove only for hygiene".</p> <p>1/15/16 - Ultrasound report stated "The ankle brachial indices (ABI) are normal bilaterally".</p> <p>1/24/16 - PT Discharge Summary stated "D/C Reason: Achieved Highest Practicable Level" and that upon discharge R217 was totally dependent without any attempts to initiate bed mobility.</p> <p>6/6/16 at 2:55 PM - Observation with E13 (RN) noted R217 to be in bed, lying on her back, asleep. R217 did have b/l Prevalon boots on, however, it was noted that the left boot was not applied properly. The resident's foot was turned inward inside the boot causing the left lateral heel to be in direct contact with the inner boot. The boot was to be positioned so that R217's heel was in the open area of the boot, thus providing a "floating" heel. E13 proceeded to correct the positioning of R217's left Prevalon boot.</p> <p>6/7/16 at approximately 3:30 PM - During an interview E2 (DON) stated that when Body audits are completed the nurse initials the ETAR signifying it was completed. If there are no new findings then that is all they document, but if there are new findings then they must complete either a pressure ulcer document in PCC or the paper copy for non pressure ulcer skin issues. E2 also stated that if there is a skin issue identified then a progress note should be written in PCC.</p> <p>6/9/16 at approximately 1:10 PM - findings were reviewed with E2 and E15 (Corporate RN/NHA).</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803		
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F 314	<p>Continued From page 32</p> <p>The facility failed to provide evidence of use of the Prevalon boots despite a care plan intervention for same, and they failed to implement an individualized turning and repositioning schedule for R217, who was identified a high risk for the development of pressure ulcers.</p> <p>2. Review of R274's medical record revealed: R274 was admitted to the facility on 5/4/16 at 3:30 PM.</p> <p>The admission nurse's note, dated 5/4/16 and timed 6:58 PM, stated that R274 was alert and oriented and a body audit was completed with no open skin areas noted.</p> <p>The admission skin assessment, dated 5/4/16 and timed 7:23 PM, stated that R274 did not have an existing pressure ulcer (PU).</p> <p>The facility's Pressure Ulcer form, dated 5/5/16 and timed 1:10 PM, identified that R274 had an existing PU on her sacrum.</p> <p>A nurse's note, dated 5/5/16 and timed 1:12 PM, stated that R274 was alert and oriented and could make her needs known to staff. A second skin assessment was completed on 5/5/16, which revealed that R274 had an open area on her sacrum measuring 0.8 x 0.6 x 0.2 cm in size with 50% slough in the wound bed. R274 stated to E3 (Wound Care RN) that the open area on her sacrum had been there for a couple of days. It was unclear how the facility failed to identify the PU on R274's sacrum during the 5/4/16 admission skin assessment.</p> <p>A nurse's note, dated 5/11/16 and timed 3:03 PM,</p>	F 314		

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F 314	Continued From page 33 stated that R274's sacral PU was unstageable and measured 0.6 x 0.6 cm in size with 100% slough in the wound bed. It was unclear why it took the facility seven (7) days since admission to stage R274's sacral PU. In an interview on 6/9/16 at 9:09 AM, E4 (RN, UM) confirmed that R274's sacral PU was not identified during the 5/4/16 admission skin assessment. In an interview on 6/9/16 at 9:40 AM, E3 (Wound Care RN) confirmed that she did not stage R274's sacral PU when it was identified on the 5/5/16 skin assessment. The sacral PU was staged on 5/11/16. Findings were reviewed with E2 (DON) on 6/9/16 at 1:40 PM. The facility failed to identify R274's sacral PU on the 5/4/16 admission skin assessment. In addition, the facility failed to stage the sacral PU identified on the 5/5/16 skin assessment until 5/11/16.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration	F 322		7/25/16

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F 322	<p>Continued From page 34</p> <p>pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, it was determined that the facility failed to provide the appropriate treatment and services to prevent aspiration pneumonia and other potential complications for one (R289) out of 42 stage 2 sampled residents. During the medication pass observation on 6/2/16, the surveyor had to intervene and stop the facility from administering medications to R289 via G-tube [GT] as they had not yet verified GT placement. Findings include:</p> <p>Review of the facility policy entitled Enteral Tubes: Medication Administration, dated February 2012, stated, "... 11. Verify enteral tube placement (referencing Enteral Tubes: Residual Checks and Irrigations/Flushes... 12. Flush tube with a minimum of 30 ml water 13. Instill each medication separately..."</p> <p>Review of the facility policy entitled Enteral Tubes: Residual Checks and Irrigations/Flushes, dated February 2012, stated, "... 7.... Residual volume checks... are completed prior to... medication administration... 10. Aspirate slowly by pulling back on the syringe until enteral tube becomes free of any residual NOTE: If the tube is in the small intestine... aspirated volume will be</p>	F 322	<p>A. For R 289, it was identified that during med administration, the Licensed nurse failed to check G tube placement. In order to protect residents in similar situations, the facility has re-educated licensed nursing staff and conducted medication pass with focus on G-tube placement as identified in Sections C and D. Additionally, the licensed nurse involved was administered 1:1 education.</p> <p>B. The DON/Designee conducted an audit to identify residents residing in facility with G tubes as other residents that have a G Tube/peg tube are at risk for not having tube checked for placement prior to medication administration.</p> <p>C. The Licensed nursed failed to check G tube placement but has been administered 1:1 education and observed on med pass.</p> <p>Detailed below and in Section D. are the measures the facility will take and the system changes to ensure the problem does not recur.</p>		

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F 322	Continued From page 35 minimal, if at all (usually less than 10 ml)... if... exceeds 60 ml: Hold... medications, discard residual, notify physician of findings and obtain further orders... If gastric residual volume is greater than 400 ml and there are no other symptoms re-feed the 400 ml... In 4 hours recheck the residual. If second residual remains above 400 mls, do not re-feed residual; hold feeding and notify physician to obtain further orders...". During the medication pass on 6/2/16 at approximately 9:30 AM, E7 (LPN) was observed giving medications to R289. E7 took the plunger out of a 60 ml syringe and was ready to administer R289's medications via his GT. The surveyor stopped E7 and asked her to check for GT placement before administering R289's medications. Facility policy is to verify enteral tube placement prior to flushing tube and administering medications. Findings were confirmed with E7 during an interview on 6/2/16 at approximately 3:55 PM. Findings were reviewed with E2 (DON) during an interview on 6/9/16 at approximately 12:00 PM.	F 322	The Staff Development Coordinator/Designee will educate licensed nursing staff on checking G tube/peg tube placement prior to medication administration. D. The DON/Designee will observe Med Pass with focus on residents identified with G Tubes/Peg Tubes to validate that they are checking for placement, this will be conducted weekly x 4, then monthly x 2. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/25/16

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F 323	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the environment was free of accident hazards for 6 rooms (116, 208, 232, 235, 237, and 241) out of 34 rooms. Findings include: During the stage 2 environmental tour on 6/6/16 from 12:30 PM to 2:00 PM, it was observed that 6 bathrooms (rooms 116, 208, 234, 235, 237, and 241) had uncovered toilet bolts with long rusty screws sticking up. During an interview findings were reviewed and confirmed by E1 (NHA), E5 (FMD) and E11 (DH) on 6/6/16 at approximately 1:45 PM.	F 323	A. 6 Bathrooms (116, 208, 234, 235, 237, 241) had the exposed rusty bolts sticking up from base of toilet covered with Bolt Caps. These bolts have been repaired and are now covered. In order to protect residents in similar situations, the Maintenance Director audited bathrooms to ensure that there are no rusty bolts exposed at the base of toilets. Any bolts that are exposed will be repaired / covered. B. The Maintenance Director/Designee audited bathrooms to ensure that there are no exposed rusty bolts that are uncovered and sticking up from the base of the toilet as residents residing in the facility have the ability to be impacted. Any additional rusty bolts exposed at the base of the toilet will be covered/repared as appropriate. C. The rusty bolts at base of toilets in room 116, 208, 234, 235, 237, 241 had not been identified during rounds. Detailed below are the measures the facility will take and systems that will be altered to ensure that the problem does not recur. It is the practice of this facility to ensure that resident environments remain as free of accident hazards as is possible. The Maintenance Director and/or designee will	

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F 323	Continued From page 37	F 323	<p>perform random weekly audits using the environmental checklist to evaluate compliance with toilet bolts.</p> <p>The Maintenance Director and/or designee will perform random weekly audits using the environmental checklist which will include evaluating toilet bases.</p> <p>The Staff Development Coordinator/Designee will in-service staff to report any issues with toilet bolts through TELs or on the 24 hour report.</p> <p>D. The Maintenance Director/Designee will conduct a random audit of one bathroom to ensure there are no exposed uncovered rusty bolts sticking up from the base of the toilet once daily for one week, then weekly for 3 weeks, then if appropriate monthly time 2 months.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>	
F 325 SS=D	<p>483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p>	F 325		7/25/16

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F 325	<p>Continued From page 38</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to ensure that one (R217) out of 42 Stage 2 sampled residents maintains acceptable parameters of nutritional status, such as body weight and protein levels. The facility failed to ensure that R217 received a protein supplement as per the recommendations of E14 (RD). Findings include:</p> <p>R217 was admitted to the facility post hospitalization on 12/8/15. Review of the clinical record revealed R217 was initially receiving nourishment via feedings through a Peg tube.</p> <p>3/22/16 at 3:46 PM - A Nutrition/Weight progress note stated, "...Pt continues on a Mechanical soft/nectar thick liquid diet with 3 meals daily...With goal to taper Pt off enteral nutrition as average meal intake improves...Recommend start PROMOD 30 cc via Peg tube BID...".</p> <p>3/22/16 through 4/7/16 - review of physician's orders lacked evidence that an order was written for R217 to receive Promod 30 cc BID via Peg.</p> <p>3/22/16 through 4/7/16 - review of the EMAR lacked evidence that R217 was receiving any Promod.</p> <p>4/7/16 - A Nutrition/Weight progress note stated, "...Recommend increase PROMOD to 30 cc via</p>	F 325	<p>A. R217 recommendations for prosource and increase flush have been reviewed with MD and orders are in place. In order to protect residents in similar situations the facility has re-educated the dietician and have monitoring in place to validate that recommendations noted in dietician's documentation have been placed into pending orders and transcribed post MD confirmation as evidenced identified in sections C and D.</p> <p>B. Residents who are evaluated by dietician, with recommendations placed in documentation are at risk to be affected.</p> <p>C. The dietician in error did not place recommendations in pending orders for licensed nursing staff to confirm with MD.</p> <p>Detailed below and in Section D. are the measures the facility will take and the system changes to ensure the problem does not recur.</p> <p>The Staff Development Coordinator in-serviced the Dietician on placing recommendations noted in documentation into pending orders.</p> <p>D. The DON/Designee will print dietician</p>	

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F 325	Continued From page 39 Peg TID..." 4/7/16 through 4/14/16 - review of physician's orders lacked evidence that an order was written for R217 to receive Promod 30 cc TID via Peg. 4/7/16 through 4/14/16 - review of the EMAR lacked evidence that R217 was receiving any Promod. 4/15/16 at 7:00 PM - a physician's order is written for R217 to receive Promod 30 cc via Peg TID. 4/16/16 through 6/6/16 - review of the EMAR revealed R217 received Promod as ordered. 6/7/16 400 PM - During an interview regarding the Promod recommendations from 3/22/16 and 4/7/16, E14 stated that she enters her own recommendations into the system (PCC) and then it gets approved by the physician. 6/9/16 at 11:25 AM - During an interview with E14, with E15 (Corporate RN/NHA) present, it was confirmed that the facility failed to input the recommendation/order initially on 3/22/16, and then on 4/7/16 for the Promod. E14 confirmed the omission was identified on 4/15/16 and then implemented.	F 325	documentation to validate that recommendations in documentation have been placed into pending orders. This audit will be weekly x 4 weeks, then monthly x 2. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		7/25/16

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F 329	<p>Continued From page 40</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R53) out of 42 stage 2 sampled residents medication regimens was free from unnecessary medications. The facility failed to provide AIMS monitoring every 6 months for R53 who received antipsychotic medication. Findings include:</p> <p>Review of the undated Abnormal Involuntary Movement Scale (AIMS) Examination Procedure instructions stated, "... Complete every six months."</p> <p>Review of R53's record revealed:</p>	F 329	<p>A. It was identified that R 53 was missing 1 AIMS examination. This AIMS examination is current and next assessment due October 2016. in order to protect residents in similar situations the facility has educated licensed nursing staff on requirements of AIMS and anti-psychotic medication as evidence identified in sections C and D.</p> <p>B. The DON/Designee will conduct an audit to identify residents on antipsychotic medication and validate that AIMS is completed every 6 months.</p>		

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F 329	Continued From page 41 R53 was admitted to the facility in June 2015 on antipsychotic medication and she continued to receive antipsychotic medication during the survey that concluded on 6/9/16. Record review revealed that AIMS testing was done on 6/30/15 (admission) and on 4/4/16. AIMS testing was not done on or about 12/30/15. E2 (DON) was interviewed on 6/7/16 at approximately 3:10 PM. E2 stated that if a new admission comes in on an antipsychotic, the facility does an AIMS on admission and then every 6 months as per the AIMS Examination Procedure (see above). Findings were confirmed with E2 during a subsequent interview on 6/7/16 at approximately 4:20 PM.	F 329	C. The facility missed one AIMS examination in error. Detailed below are the measures the facility will take and the system changes to ensure the problem does not recur. The Staff Development Coordinator/Designee will in-service licensed nursing staff on medications that fall under the classification of antipsychotics. The Staff Development Coordinator/Designee will educate licensed nursing staff on requirements of AIMS exam, who receives one and how and when to complete. D. DON/designee will validate that AIMS exams are completed on residents identified as receiving antipsychotic medication every 6 months weekly times 4, then monthly times 2. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		7/25/16	

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F 332	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review, interview and medication pass observation, it was determined that the facility failed to ensure that it was free of medication error rates of 5% or greater. The medication error rate for the medication pass observation was 2 out of 25 opportunities which was 8%. Findings include: 1. On 6/2/16 at approximately 9:05 AM, E7 (LPN) administered Loratadine 10 mg tablet from stock which she crushed and gave via GT to R289. When the medication given was reconciled to the current physician order, dated 5/20/16, the order stated, "Loratadine syrup 5 mg/ml give 10 ml via G-tube one time a day...". R289's Loratadine was not given in accordance with the prescriber's orders. Findings were reviewed with E7 during an interview on 6/2/16 at approximately 3:55 PM. E7 subsequently checked the medication cart and confirmed that R289 had his own bottle of Loratadine syrup. E7 stated, "I must have read (the MAR) wrong." 2. On 6/9/16 at approximately 8:30 AM, E8 (RN) crushed Metoprolol ER [extended release] and was going to add pudding to it to administer to R104. The surveyor stopped her, however, as Metoprolol ER was not to be crushed due to its extended release properties. Metoprolol is used to treat chest pain and high blood pressure and crushing it causes the medication to be released all at once instead of slowly over 24 hours, which can result in a dangerously low blood pressure	F 332	A. Incident Report was created for R289 and R104. Licensed nurse was provided with 1:1 education. In order to protect residents in similar situations the facility re-educated licensed nursing staff on medication administration with focus on non-crushable medications and converting tablets to liquid form. Additionally nurses have been observed during medication pass as evidence identified in sections C. and D. B. Residents residing in facility receiving medications are at risk to be affected. C. Licensed Nurses observed during med pass during survey made an error. Detailed below are the measures the facility will take and system changes to ensure the problem will not recur. 1:1 education will be provided to Licensed Nursing Staff involved in 8% med error rate Licensed Nursing Staff will be observed during medication administration. The Staff Development Coordinator/Designee will in-service licensed nursing staff on refraining from crushing extended release tablets and those that are enteric coated.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK 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)	(X5) COMPLETION DATE	
F 332	Continued From page 43 and other potential complications. Findings were reviewed with E8 on 6/9/16 at approximately 8:30 AM. E8 returned to the medication cart and checked Metoprolol which included a label stating, "do not crush or chew". E8 confirmed the finding and stated that she usually administers R104's Metoprolol by mouth when she is up and more awake, but she crushed it because R104 was still in bed and sleepy. Findings were reviewed with E2 (DON) on 6/9/16 at approximately 12:00 PM.	F 332	The Staff Development Coordinator/Designee will in-service licensed nursing staff that when interchanging a liquid for pill form in same dosage, MD must be notified. D. The DON/Designee will randomly observe licensed nursing staff during med pass to validate that extended release tablets and those that are enteric coated are not crushed. This audit will be weekly x 4 weeks, then monthly x 2 months. The DON Designee will randomly observe licensed nursing staff during med pass to validate that when interchanging a liquid for a pill form in same dosage, the MD is notified. This audit will be weekly x 4 weeks, then monthly x 2 months. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, interview and medication pass observation, it was determined that the facility failed to be free of significant	F 333	A. R104 Did not receive the crushed medication. An incident report was created. In order to protect residents in	7/25/16	

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F 333	<p>Continued From page 44</p> <p>medication errors for one out of 25 opportunities. On 6/9/16 during the medication pass observation, the facility crushed Metoprolol ER and was ready to mix it in pudding to administer to R104, however, the surveyor stopped the medication from being administered in the crushed form. Metoprolol ER had a label on it stating, "do not crush or chew." Findings include:</p> <p>Review of R104's current physician orders included Metoprolol ER 25 mg by mouth daily.</p> <p>On 6/9/16 at approximately 8:30 AM, E8 (RN) crushed Metoprolol ER and was going to add pudding to it to administer to R104. The surveyor stopped her, however, as Metoprolol ER was not to be crushed due to it's extended release properties. Metoprolol is used to treat chest pain and high blood pressure and crushing it causes the medication to be released all at once instead of slowly over 24 hours, which can result in a dangerously low blood pressure and other potential complications.</p> <p>Findings were reviewed with E8 on 6/9/16 at approximately 8:30 AM. E8 returned to the medication cart and checked Metoprolol which included a label stating, "do not crush or chew". E8 confirmed the finding and stated that she usually administers R104's Metoprolol by mouth when she is up and more awake, but she crushed it because R104 was still in bed and sleepy. E8 stated that she subsequently had R104's Metoprolol order changed to 12.5 mg by mouth twice a day (not in the ER form).</p> <p>Findings were reviewed with E2 (DON) on 6/9/16 at approximately 12:00 PM.</p>	F 333	<p>similar situations the facility re-educated licensed nursing staff on medication administration with focus on non-crushable medications and a 1:1 education was provided to the Licensed Nurse. Additionally nurses have been observed during medication pass as evidence identified in sections C. and D.</p> <p>B. Residents residing in facility receiving medications are at risk to be affected.</p> <p>C. Licensed Nurse observed during med pass during survey mad an error.</p> <p>Detailed below are the measures the facility will take and the system changes to ensure the problem does not recur.</p> <p>1:1 education provided to Licensed Nurse involved in crushing the extended release medication.</p> <p>The Staff Development Coordinator/Designee will in-service licensed nursing staff on refraining from crushing extended release tablets and those that are enteric coated.</p> <p>D. The DON/Designee will randomly observe licensed nursing staff during med pass to validate that extended release tablets and those that are enteric coated are not crushed. This audit will be weekly x 4 weeks, then monthly x 2 months.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as</p>	

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F 333	Continued From page 45	F 333		
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store and serve food under sanitary conditions in the second floor nourishment room to prevent the outbreak of food-borne illness. Findings include: On 6/2/16 at 9:10 AM, the bottom tray of the nourishment refrigerator on the second floor was observed to have brown dirty liquid. During an interview findings were reviewed and confirmed by E5 (FMD) and E11 (DH) on 6/6/16 at approximately 1:45 PM.</p>	F 371	<p>appropriate. The committee will determine need for further audits and/or action plans.</p> <p>A. In order to protect residents in similar situations, the bottom tray of the nourishment room refrigerator on the second floor was cleaned and the brown liquid was cleaned up.</p> <p>B. - The Housekeeping Manager/Designee audited refrigerators in nourishment rooms to ensure that they are appropriately cleaned as residents residing in the facility have the ability to be impacted. Any new spills that are identified will be cleaned.</p> <p>C. The second floor nourishment room refrigerator spill had not been identified as not being cleaned during rounds.</p> <p>Detailed below are the measures the</p>	7/25/16

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F 371	Continued From page 46	F 371	<p>facility will take and the system changes to ensure that the problem does not recur.</p> <p>It is the practice of this facility to store, prepare, and distribute and serve food under sanitary conditions.</p> <p>The refrigerators on the units will be randomly checked to ensure that spills are cleaned.</p> <p>The Staff Development Coordinator/Designee will in-service staff to report any issues with spills in nourishment room refrigerators through TELs or on the 24 hour report. The Staff Development Coordinator/Designee will in-service housekeeping staff to check refrigerators in the nourishment room and clean up spills.</p> <p>D. The Housekeeping Manager/Designee will conduct an audit of refrigerators to ensure they are cleaned daily for one week, then weekly for three weeks, then if appropriate monthly time 2 months.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>		
F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system</p>	F 463		7/25/16	

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F 463	<p>Continued From page 47 from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that all resident rooms (Room 107B) had functional call systems. Findings include:</p> <p>On 6/2/16 at 10:55 AM, it was observed that room 107 B bed's call bell was not working. The finding was confirmed by E12 (CNA).</p> <p>During an interview findings were reviewed with E1 (NHA), E5 (FMD) and E11 (DH) on 6/2/16 at approximately 1:45 PM.</p>	F 463	<p>A. Room 107B Call bell was tested during survey and is working correctly. In order to protect residents in similar situations, the facility will audit call bells in the facility to ensure they are functioning appropriately.</p> <p>B. The Maintenance Director/Designee will audit call bells to ensure they are functioning appropriately as residents residing in the facility have the ability to be impacted. Any call bells that are identified as not functioning appropriately will be repaired/replaced as appropriate.</p> <p>C. The call bell in 107B had not been identified as not functioning properly during rounds, however has been evaluated by Maintenance Director and is operating correctly.</p> <p>It is the practice of this facility that nurses' station is equipped to receive resident calls through a communication system.</p> <p>Detailed below are the measures the facility will take and the system changes to ensure that the problem does not recur.</p> <p>The Maintenance Director and/or designee will perform random audits each month testing the functionality of the call bell system through the TELs system.</p>	

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F 463	Continued From page 48	F 463	<p>The Staff Development Coordinator/Designee will in-service staff to report any issues with non-functioning call bells through TELs or on the 24 hour report.</p> <p>D. The Maintenance Director/Designee will conduct an audit of 10 call bells daily for one week, then weekly for 3 weeks, then if appropriate monthly time 2 months.</p> <p>Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.</p>		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services of Wilmington

DATE SURVEY COMPLETED: June 9, 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 survey was conducted at this facility from June 2, 2016 through June 9, 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 110. The Stage 2 survey sample size was 42.</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 9, 2016: F241, F246, F253, F256, F279, F309, F314, F322, F323, F325, F329, F332, F333, F371, and F463</p>	<p>Please cross reference Federal POC for Survey Ending 6/9/16 for F-Tags F241, F246, F253, F256, F279, F309, F314, F322, F323, F325, F329, F332, F333, F371, and F463.</p>	<p>7/25/16</p>

Provider's Signature Robert John Title Administrator Date 7/25/16