

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

PRINTED: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

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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 C 01/12/2015 |
| 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 complaint investigation survey was conducted at this facility from January 6, 2015 through January 12, 2015. The deficiencies contained in this report are based on observation, interviews and review of clinical records and other facility documentation. The facility census the first day of the survey was 113. The survey sample totaled 6 residents which included review of 2 closed records and 4 active records.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON- Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set (standardized assessment form used in nursing homes); RNAC - Registered Nurse Assessment Coordinator; Activities of Daily Living-activity needed for daily living such as dressing, hygiene, eating, toileting and bathing; Coccyx-tailbone area; BP-Blood Pressure-the measure of force of the blood against the walls of a blood vessel; PU-Pressur ulcer-sore area of skin that develops when the blood supply to it is cut off due to pressure; Stage 2 pressure ulcer -skin forms an open sore. The area around the sore may be red and irritated; Unstageable (tissue loss in which actual depth of the ulcer is unable to be determined due to the</p> | F 000 | <p>F280 – RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>#1 – R6 no longer resides in the facility.</p> <p>#2 – The Administrative Director of Nursing Services (ADNS)/Designee will audit resident records to ensure that residents with a pressure ulcer have an appropriate care plan in place.</p> <p>#3 The wound care nurse failed to update R6's careplan when the pressure ulcer became unstageable. The Staff Development Coordinator/Designee will inservice the Wound Care Nurse and the Wound Care Team that when a resident's pressure ulcer changes, the resident's Care Plan will be reviewed and updated as appropriate.</p> | 2/4/15 | |

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

Robert D. [Signature]

TITLE

Administrator

(X6) DATE

1/30/15

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 presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black that is more severe than slough in the wound) pressure ulcer; Incontinence-loss of control of bladder and/or bowel function; Rectal-final portion of the large intestines. | F 000 | #4 The ADNS/Designee will audit up to 5 residents with pressure ulcers weekly times four weeks to determine if a resident's pressure ulcer has changed, and if a change has occurred that the care plan has been reviewed and updated as appropriate. The Interdisciplinary Team will review resident's with pressure ulcers during the Interdisciplinary Team Meeting and evaluate that care plans are appropriate. Results of the audits conducted by the ADNS/Designee will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans. | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Cross-refer to F309 example 2 Based on record review and interview, it was determined that for one (R6) out of 6 sampled residents, the facility failed to ensure a care plan | F 280 | | | |

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| F 280 | Continued From page 2 was revised to reflect the resident's current status. Finding includes: R6 was re-admitted to the facility from the hospital on 12/29/14 with a stage 2 pressure ulcer on the coccyx. According to R6's admission MDS assessment dated 12/29/14, R6 required extensive assistance of staff for Activities of Daily living. R6's admission care plan, initiated on 12/29/14 stated, "At risk for alteration in skin integrity...". This care plan was reviewed on 12/30/14. On 12/30/14 a revised care plan was initiated entitled, " Stage 2 pressure ulcer at coccyx related to impaired mobility, incontinence and friction" On 1/7/15, a nurse's note stated ...patient continue with sacral ulcer...the wound bed is 100% slough and unstageable. According to the 12/30/14 care plan, this care plan was reviewed on 01/09/15 and initiated the goal, will heal within the limits of the disease process. However, the care plan was not revised to identify and address the change in the condition of the pressure sore from stage 2 to unstageable. This finding was discussed with E1(NHA) and E3 (ADON) and E8 (RN) on 1/12/15 at approximately 12:00 PM. | F 280 | | | |
| F 283 SS=D | 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS | F 283 | | | |

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| F 283 | <p>Continued From page 3</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</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 2 (R1 and R4) out of 6 sampled residents, had discharge summaries that included a recapitulation of their stay in the facility. Findings include:</p> <p>1. R1 was admitted to the facility from the hospital on 5/27/14 with diagnoses of severe heart disease. R1 was also admitted with an open area to the sacrum (area above the tailbone) and was dependent upon staff for all activities of daily living.</p> <p>Nurse's note, dated 5/28/14, stated that R1's sacral pressure ulcer increased in size and became unstageable.</p> <p>The facility initiated a care plan dated 5/29/14, for "Resident shows potential for discharge and expresses wish for discharge".</p> <p>According to a Physician's progress note dated 6/13/14, R1's sacral wound was worsening.</p> <p>On 6/25/14, a nurse's note revealed that R1's sacral wound continued to worsen and his left</p> | F 283 | <p>F283 – ANTICIPATE DISCHARGE:RECAP STAY/FINAL STATUS</p> <p>#1 - R1 and R4 no longer resides in the facility.</p> <p>#2 – The Administrator/Designee will audit residents who are currently scheduled for discharge in the upcoming seven days to ensure that a Discharge Summary is completed for discharging resident.</p> <p>#3 – The Discharge Summary was not completed for the two residents indicated above, however the facility was completing a Discharge Instructions Form, which was given to residents at time of discharge.</p> <p>The Staff Development Coordinator/Designee will inservice Directors of Care Delivery that a Discharge Summary will be completed by the Interdisciplinary Team for discharged residents.</p> | 2/4/15 | |

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| F 283 | <p>Continued From page 4</p> <p>heel was boggy (feeling as though it's filled with fluid).</p> <p>Review of R1's record indicated he was discharged on 6/26/14. During an interview with E7 (Social Worker) on 1/8/15 at approximately 1:30 PM, she stated that R1 was discharged under the care of (name of agency). There was no discharge summary to recapitulate R1's stay in the facility when reviewed on 1/8/15.</p> <p>E2 (DON) was interviewed on 1/9/15 at approximately 2:00 PM, and confirmed that R1 had no discharge summary.</p> <p>2. R4 was admitted to the facility on 8/4/14 from the hospital after a left knee replacement.</p> <p>According to R4's admission MDS assessment, dated 8/6/14, R4 needed extensive assistance with her activities of daily living.</p> <p>The facility initiated a care plan dated 8/18/14 on "Patient shows Potential for discharge and expresses wish for discharge."</p> <p>According to Physical Therapy (PT) documentation from 8/5/14 - 8/26/14, R2 met some of her goals. PT recommended continued PT outpatient services for range of motion exercises and strengthening. Occupational Therapy documentation from 8/5/14 - 8/26/14 indicated that R4 needed minimum assistance with homemaking, "at roller walker level" with supervision and a bench and grab bar in her shower.</p> <p>According to a nurse's progress note dated 8/27/14, Resident was discharged home (Name</p> | F 283 | <p>#4 The Administrator/Designee will audit 10 discharged resident records weekly times four weeks to ensure that the Discharge Summary was completed.</p> <p>Discharge Summaries will be reviewed by the Interdisciplinary Team during the Interdisciplinary Team Meeting.</p> <p>Results of the audits conducted by the Administrator/Designee will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.</p> | | |

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| F 283 | Continued From page 5 of Home Care Agency) to follow. Review of R4's clinical record revealed lack of a discharge summary to recapitulate R4's stay in the facility. E2 was interviewed on 1/9/15 at approximately 2:00 PM, and confirmed R4 had no discharged summary. | F 283 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that two (R2 and R6) residents, out of 6 sampled, received the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R2, who received three kinds of blood pressure (BP) medications, failed to have her BP consistently monitored to prevent potential negative outcomes. Nursing staff failed to recognize and clean the stool in R6's rectal area, before and immediately after treatment and a dressing change, of R6's open sacral (area above the tailbone) pressure ulcer. | F 309 | F309- PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING #1 R2 has had baseline vital signs entered in Point Click Care to notify nursing staff of significant variances to baseline vitals. R6 No longer resides in the facility. #2 The ADNS/Designee will audit resident records to ensure that baseline vital signs are recorded. The ADNS/Designee will audit existing residents to determine which residents require dressing changes due to pressure ulcers. #3 Baseline vital signs were not entered for R2. Additionally, licensed nursing staff failed to | 2/4/15 |

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| F 309 | <p>Continued From page 6</p> <p>Findings include:</p> <p>R2 was admitted to the facility from the hospital on 11/7/14 with diagnoses that included high blood pressure, aphasic (difficulty talking), stroke, difficulty swallowing and an anxiety (nervousness, fear and worrying) disorder.</p> <p>R2's admission MDS assessment, dated 11/14/14, indicated that R2 was dependent on staff for all of her activities of daily living.</p> <p>R2 was prescribed the following drugs to treat her high blood pressure on 11/07/14: Labetalol HCl tablet 200 mg (milligrams) by mouth three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. Norvasc 10 mg tablet by mouth once a day at 8:00 AM. Valsartan tablet 160 mg by mouth twice a day at 8:00 AM and 4:00 PM.</p> <p>The facility developed a care plan, dated 11/09/14, for Cardiac (heart) Disease related to hypertension, history of Cardiovascular Disease (heart and blood vessels). The goal of this care plan was that R2 would experience effective symptom management.</p> <p>Care plan interventions included "Notify physician if heart rate less than 50" and "obtain vital signs (blood pressure, pulse, respiration, including heart rate) as indicated, report changes to physician". The facility initiated daily blood pressure monitoring starting on admission (11/7/14).</p> <p>R2's clinical record indicated that R2's vital signs were taken once or twice a day. Review of R2's</p> | F 309 | <p>follow up on significant variance in blood pressure readings because resident was asymptomatic.</p> <p>The Staff Development Coordinator/Designee will inservice licensed nursing staff that residents will have initial vital signs recorded as baseline and when vital signs entered indicate a significant variance from baseline, vitals will be followed-up appropriately.</p> <p>The Staff Development Coordinator/Designee will inservice the Wound Care Nurse and the Wound Care Team to ensure that a thorough skin check is done at the time of a dressing change on a sacral wound to ensure that incontinent care is addressed.</p> <p>The Interdisciplinary Team will review vitals during the Interdisciplinary Team Meeting.</p> | | |

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| F 309 | <p>Continued From page 7</p> <p>BP's between 11/7/14 and 11/20/14 revealed that R2's systolic (highest pressure when the heart beats to push the blood to the rest of the body by way of the arteries) BP ranged from 127 to 154 and the diastolic pressure (lowest pressure when the heart relaxes between beats) ranged from 59 to 79, indicating that the BP medications were effective.</p> <p>On 11/21/14 at 3:05 PM, R2's BP was 107/54 which was significantly lower than the previous readings. There were no other recorded BP readings on 11/21/14. E6 (RN) confirmed with the surveyor on 1/9/15 at approximately 3:30 PM that there was no recorded evidence that a re-check or other readings of R2's BP were done on 11/21/14. Additionally, on 11/22/14 and the morning of 11/23/14, there were no BPs recorded. R2's 11/14 Medication Administration Record (MAR) indicated that R2 continued to receive Labetalol, Valsartan and Norvasc as prescribed on 11/21/14, 11/22/14 and 11/23/14 despite the change in vital signs.</p> <p>On 11/23/14 at 1:05 PM, a Change of Condition nursing note stated, "Therapy reported resident had a low blood pressure of 103/45 and a heart rate of 55...Resident complained of dizziness and nausea, blood pressure rechecked results at approximately 1200..105/54. Resident reassessed approximately 20 minutes later. BP at that time was 98/50....Resident assisted back into bed, feet elevated...NP(Nurse Practitioner) was notified, new orders received to add parameters to antihypertensives, increase fluid, obtain CBC (complete blood count) and BMP (blood for Basic Metabolic Panel) and obtain EKG (electrocardiogram/to check electrical activity of the heart)...laboratory was notified of STAT</p> | F 309 | <p>#4 The ADNS/Designee will observe dressing changes on one resident weekly times four weeks to ensure that licensed nurse assesses the area and addresses incontinent issues.</p> <p>The ADNS/Designee will randomly audit 10 residents per unit daily times one week to ensure that vital signs are taken/documentated as required and that appropriate follow-up/action was taken when vitals have a significant variance from baseline. Then the ADNS/Designee will randomly</p> <p>audit 10 resident s per unit once per week for three weeks to ensure that vitals are taken/documentated as required and that appropriate follow-up/action was taken when vitals have a significant varlance from baseline.</p> | | |

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| F 309 | <p>Continued From page 8</p> <p>(urgent) labs...Mobilex for EKG...Resident is currently in bed resting comfortably vital signs at this time are as follows: 110/52 and heart rate is 55."</p> <p>A new physician's order was initiated on 11/24/14 for the Labetalol and Norvasc to be held (not given) for Systolic less than 110 and to discontinue the administration of the Valsartan.</p> <p>The facility failed to ensure that R2's BP was consistently monitored and assessed to prevent a negative outcome.</p> <p>Findings were discussed with E1 (NHA), E3 (ADON) and E8 (RN) on 1/12/15 at approximately 12:00 PM.</p> <p>2. R6 was re-admitted to the facility from the hospital on 12/29/14 with a stage 2 pressure ulcer on the coccyx and redness to the surrounding area.</p> <p>According to R6's admission MDS assessment dated 12/29/14, R6's cognition was intact (alert and oriented to person, place and time) and she needed extensive assistance from staff for her Activities of Daily living. Additionally, R6 was incontinent of bowel and bladder.</p> <p>R6's admission care plan initiated on 12/29/14 stated, "At risk for alteration in skin integrity related to Incontinence,...".</p> <p>On 12/30/14 a second care plan was initiated for " Stage 2 pressure ulcer at coccyx related to Impaired mobility, incontinence and friction"</p> <p>On 1/7/15 it was documented that R6 had an</p> | F 309 | <p>Results of the audits conducted by the ADNS/Designee will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.</p> | | |

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| F 309 | <p>Continued From page 9 unstageable sacral pressure ulcer.</p> <p>On 1/9/15 at 11:15 AM, E4 (RN) was observed providing treatment and a dressing change to R6's sacral pressure ulcer.</p> <p>E5 (LPN) turned R6 on her side for wound care. E5 stated R6's adult pad was recently changed. However, the surveyor noted that a soft formed stool, somewhat flattened and about the size of a silver dollar was on the rectal area.</p> <p>E4 proceeded to do R6's wound treatment and dressing change. E4 and E5 replaced the same adult pad without checking the rectal area. She then closed the adult pad around R6's waist area and thereby covered the stool in R6's rectal area.</p> <p>While E5 was with R6 in the room, the surveyor told E4 that R6 had a stool on her rectal area and she did not clean the area before and after the treatment procedure. E4 and E5 denied seeing the stool. E5 insisted that R6 was just cleaned prior to the treatment and dressing change. The surveyor, E4 and E5 went back to the resident's room as per the surveyor's request and all three saw the stool on top of R6's rectal area when E5 released R6's adult pad.</p> <p>The facility failed to ensure that R6 was checked for incontinence of bowel and failed to provide incontinence care as needed before the treatment and dressing change of the sacral pressure ulcer.</p> <p>This finding was discussed with E1, E3, and E8 on 1/12/15 at approximately 12:00 PM.</p> | F 309 | | | |



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
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Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

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NAME OF FACILITY: Manor Care -Wilmington

DATE SURVEY COMPLETED: January 12, 2015

| 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 January 6, 2015 through January 12, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 113. The survey sample totaled six (6) which included review of two (2) closed records and four (4) active records.</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>PLEASE CROSS REFERENCE FEDERAL POC FOR SURVEY ENDING 1/12/2015 FOR FTAGS F280, F283, F309</p> | <p>2/11/15</p> |

Provider's Signature

Robert D. [Signature]

Title

Administrator

Date

1/30/15



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| | | | |
|--|--|--|--|
| | <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey exit date 1/12/2015, citations are F280, F283 and F309.</p> | | |
|--|--|--|--|

Provider's Signature Folmet J. [Signature] Title Administrator Date 1/30/15