

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

PRINTED: 03/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2016
NAME OF PROVIDER OR SUPPLIER MILTON & HATTIE KUTZ HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 704 RIVER ROAD WILMINGTON, DE 19809		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual recertification survey was conducted at this facility from February 23, 2016 through March 2, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 87. The Stage 2 survey sample size was 52.</p> <p>Abbreviations/definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RNAC - Registered Nurse Assessment Coordinator; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; EMR - Electronic Medical Record; FMD - Facility Maintenance Director; AFMD - Assistant Facility Maintenance Director; MAR - Medication Administration Record; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); POS - physician order sheet; TAR - treatment administration record; SSD - Social Service Director; FSD - Food Service Director; AC - Air Conditioning; Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Antibiotic - medication used to treat bacterial infections; Asymptomatic - producing or showing no</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **5/9/16**

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 symptoms; Bacteriuria - presence of bacteria in the urine; BID - twice a day; BM- bowel movement; BMP - Basic Metabolic Panel, set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; cm - centimeter, unit of length; Cubic Centimeter/ cc - a unit of capacity, volume; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; CMP- comprehensive metabolic panel- test that measures your sugar level, electrolyte and fluid balance, kidney function and liver function; COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Dialysis port/catheter - small tube which has an opening for blood flow out of the body and another opening for blood return after it flows through the dialysis machine; catheters are usually inserted in the chest or neck; Donning/don-put on; Dulcolax suppository - a stimulant laxative inserted into the rectum used to treat constipation; Dysuria - difficult or painful urination; e.g.-for example; Epithelial - new, pink/shiny tissue; Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed; F/Fahrenheit - temperature scale; Flank - area between the ribs and the hip;	F 000		

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F 000	<p>Continued From page 2</p> <p>Fleets Enema - a lubricant laxative inserted into the rectum that works by slowing the absorption of water from the bowel, which softens the stool; Granulation - pink/beefy red tissue, shiny/moist; Hematuria - blood in the urine; Hospice - service that provides care to residents that are terminally ill; Hyperlipidemia- high cholesterol &/or triglycerides (fat proteins) associated with increased risk for heart disease and stroke; Incontinence/Incontinent - loss of control of bladder &/or bowel function; International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Pressure Ulcer Classification System identifies the following six (6) categories/stages: - Stage I: intact skin with non-blanchable redness of a localized area usually over a bony prominence; area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. - Stage II: presents as a shallow open ulcer with a red pink wound bed, without slough; may also present as an intact or open/ruptured serum-filled blister; presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury/sDTI). - Stage III: full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss. - Stage IV: full thickness tissue loss with exposed bone, tendon or muscle; slough or eschar may be present. - Unstageable: full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. - sDTI: purple or maroon localized area of</p>	F 000		

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F 000	Continued From page 3 discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear; area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Lewy Body Dementia - progressive dementia that leads to a decline in thinking, reasoning and independent function because of abnormal microscopic deposits that damage brain cells over time; LFT - Liver Function Test; Lipid Profile-panel of blood tests that serves as an initial broad medical screening tool for abnormalities in lipids, such as cholesterol and triglycerides; MOM/Milk of Magnesia- a laxative medication used to treat constipation; Necrotic - dead; non-viable tissue; NN - nurse's notes; Nystatin ointment - used to treat fungal infections on the surface of the skin; Organisms - various types of bacteria; Parkinson's Disease- progressive disorder of the nervous system that affects movement such as symptoms of shaking hands, poor balance, stooped posture; Periwound - area of tissue/skin surrounding a pressure ulcer/sore (PU); PR - per rectum, the final section of the large intestine, terminating at the anus; Pressure sore/ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; PRN - as needed; Pyuria - presence of pus in the urine, typically from bacterial infection; R/RT - right; Sacrum/sacral - large triangular bone at the base of the spine;	F 000			

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F 000	Continued From page 4 Severe Cognitive Impairment - unable to make own decisions; Slough - yellow, tan, gray, green or brown dead tissue; Suprapubic - area over the bladder; Urine - fluid waste formed by the kidney and excreted from the bladder; Urine Analysis (UA) - diagnostic test used to detect and assess a disease or illness or infection; Urine culture and sensitivity (C&S) - a microscopic study of the urine culture performed to determine the presence of pathogenic bacteria in patients with suspected urinary tract infection; (UTI)-Urinary Tract Infection - bacteria in urine; > - greater than; = - equal.	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 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to promote an environment that maintained or enhanced dignity and respect in full recognition of 23 (R2, R13, R21, R28, R29, R31, R32, R33, R37, R39, R51, R58, R59, R63, R65, R73, R76, R78, R79, R82, R88, R90, and R95) out of 87 residents' individuality. Findings include: 1. During a dining observation of the Satellite	F 241		

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F 241	<p>Continued From page 5</p> <p>dining room on 2/23/16 at 12:25 PM, disposable plastic drinking cups and/or dessert containers were observed in use for the following three (3) residents: R13, R63, and R95.</p> <p>2. During a dining observation of tray service in resident rooms on 2/23/16 at 12:40 PM, disposable plastic drinking cups and/or dessert containers were observed in use for R21 and R29.</p> <p>3. During a second dining observation of the Satellite dining room on 2/29/16 at 12:20 PM, disposable plastic drinking cups, dessert containers and/or Styrofoam bowls were observed in use for the following 13 residents: R2, R13, R28, R32, R37, R39, R58, R63, R65, R73, R82, R90, and R95.</p> <p>4. During a second dining observation of tray service in resident rooms on 2/29/16 at approximately 12:45 PM, a disposable Styrofoam dessert container was observed in use for R59.</p> <p>In an interview with E2 (DON) on 3/1/16 at approximately 3:30 PM, the above listed findings were reviewed.</p> <p>5. During a lunch observation in the satellite dining room on 2/23/16 from approximately 12 PM - 12:45 PM, disposable plastic drinking cups (4 and 6 ounce) and small disposable plastic bowls used for dessert were observed in use for the following 11 residents: R2, R28, R32, R37, R39, R58, R65, R73, R78, R82, and R90.</p> <p>Findings were reviewed with E1 (NHA), E2 and E3 (ADON) on 3/2/16 at approximately 4:15 PM during the exit conference.</p>	F 241	<p>F 241</p> <p>A. All residents identified, and all others are no longer being served using disposal products</p> <p>B. To insure that dignity is maintained for all residents on an ongoing basis in all dining areas, new tableware has been purchased to replace disposable products; supply will be reviewed routinely, and new products ordered when needed</p> <p>C. To ensure that an adequate supply of (non-disposable) tableware is available on an ongoing basis, a new tableware inventory system has been established to monitor the supply of tableware (see attached form D-1). In addition, the Meal evaluation form has been revised to now include review of disposable product use on a weekly basis (see attached D-2). The Meal Evaluation form will be completed weekly by a Dining Services supervisor. Director of Dining Service will provide in-service training for the Dining Services staff on the use of the new Tableware Inventory form and the new Meal Evaluation form. Inservice for existing staff will be provided by April 29, 2016, and upon hire for new staff, and at least annually by the Director of Dining Service</p> <p>D. Director of Dining Services or designee will monitor the Meal Evaluation forms, and complete the Inventory log every two weeks for 2 months, and then monthly for 3 months, then reviewed quarterly for 12 months for 100% compliance. Results will be reported at the monthly QAPI meetings for 12 months for evaluation, discussion and program compliance.</p>	4/29/2016

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F 241	Continued From page 6 6. During a second dining observation in the patio dining area, off of the 600 unit, on 2/29/16 at 12:27 PM, disposable, plastic water and juice cups were observed for six residents, R31, R33, R51, R76, R79 and R88. Additionally, styrofoam dessert bowls and disposable, plastic dessert cups were observed for five of the six residents, R31, R33, R51, R76 and R88. On 2/29/16 at 12:47 PM, in an interview, E7 (LPN) stated disposable cups and bowls had been used for some time and did not know why they were being used. On 3/2/16 at 2:15 PM, in an interview, E6 (FSD) stated the facility did not have enough reusable cups, dessert cups and bowls for all of the residents to serve for meals resulting in using disposable ones. The facility failed to promote an environment that maintained each resident's dignity related to the use of disposable cups and bowls at meals for 23 residents during the dining observations. On 3/2/16 at 2:15 PM, E6 confirmed the findings.	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews during the environmental tour with E10 (FMD) on 3/1/16	F 253			

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F 253	<p>Continued From page 7</p> <p>between 9:45 AM and 10:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 16 [103, 104, 107, 201, 206, 302, 304, 401, 404, 407, 408, 507, 601, 604, 605 and 607] out of 30 rooms reviewed. Findings include:</p> <p>The following observations were made during the environmental tour:</p> <p>Room 103 - Bathroom sink was slow draining;</p> <p>Room 104 - Bathroom sink was slow draining;</p> <p>Room 107 - Unpainted areas of wall in the bathroom doorway and by the sink; - Chipped paint on the wall opposite the toilet;</p> <p>Room 201 - The foot of the bed had large scrape marks;</p> <p>Room 206 - Over bed table scraped and in disrepair;</p> <p>Room 302 - Bathroom and bedroom walls had chipped paint; - Small hole in drywall under the bathroom sink; - Dirty floor tiles in the bathroom; - Sink slow draining; - Two uncovered bedpans stored on floor next to the toilet;</p> <p>Room 304 - Unpainted area of wall in the bathroom by the</p>	F 253	<p>F 253 Room 302.</p> <p>A. All bedpans in resident use were properly cleaned, covered with clear designated plastic bags and stored in designated resident's dresser bottom drawer.</p> <p>B. Inspected all residents rooms to ensure all bedpans were properly stored.</p> <p>C. Staff educator or designee will re-in service all the nursing staff on how to properly clean and store bed pans by 4/29/2016, upon hire of new staff and at least annually.</p> <p>D. Unit Managers or Supervisors during their daily rounds will inspect and monitor all resident rooms and document on supervisors report daily until 100% compliance is achieved that bed pans are being cleaned and stored away properly x 4 consecutive weeks, then until 100 % compliance is achieved weekly x 4 months, and then until 100% compliance is achieved quarterly x 2 quarters. Results will be reported monthly at our safety rounds meetings and monthly QAPI meetings for review, discussion and evaluation.(see attached N-17)</p>	4/29/2016

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F 253	Continued From page 8 heater; Room 401 - Chipped paint on bedroom wall near bathroom entrance; - AC vent was dirty; Room 404 - Unpainted area on the bathroom wall; - Vent underneath sink was corroded; - Bedroom walls had chipped paint; - AC vent was dusty; - Small hole at top of the electrical outlet on the wall next to the television; Room 407 - Walls in bedroom had chipped drywall and peeling paint; - Bathroom door did not close easily; - Dirty and cracked tiles found throughout the bedroom and bathroom; - AC panel was loose; Room 408 - Walls in bathroom had chipped and peeling paint; - Walls in bedroom had chipped drywall and peeling paint; - Closet handle on right side was hanging due to missing screw; - AC vent was dirty; Room 507 - Dirty and cracked tiles found throughout the bedroom and bathroom; Room 601 - Dirty and cracked tiles found throughout the bedroom and bathroom;	F 253	F 253. A.No residents were directly affected by this practice. All identified items were addressed 3/2/2016 as noted below: • Room 103-Sink drain cleared. • Room 104-Sink drain cleared. • Room 107-All chipped and damaged areas patched and painted. • Room 201-Foot of bed sanded and touched up. • Room 206-Over bed table replaced. • Room 302-All areas pathed and painted. Bathroom floor cleaned. Sink drain cleared. • Room 304-All areas patched and painted. • Room 401-All areas patched and painted. A/C vent cleaned. • Room 404-All areas patched and painted. Vents cleaned and touched up. • Room 407-All areas painted and patched. Bath door on order. A/C cover repaired. Bath floor cleaned. • Room 408-All areas patched and painted. Repaired closet handle. Cleaned vent. • Room 507-Floor cleaned. • Room 601-All areas patched and painted. Floor cleaned. Tightened door knob. • Room 604-All areas patched and painted. Floor cleaned. • Room 605-Floor cleaned. • Room 607-All areas patched and painted. Floor cleaned. • All cracked or damaged floor tiles, in all of the aforementioned rooms, to be replaced.		

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F 253	Continued From page 9 - Hole in bedroom wall below cork board; - Front door knob was loose; Room 604 - Dirty and cracked tiles found throughout the bedroom and bathroom; - Scrape marks by front door frame; Room 605 - Dirty and cracked tiles found throughout the bedroom and the bathroom; Room 607 - Dirty and cracked tiles found throughout the bedroom and the bathroom; - Paint scraped off the wall adjacent to the wall mirror. Findings were reviewed and confirmed with E10 during the environmental tour. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 3/2/16 at 4:30 PM.	F 253	Cont: F253 B. An audit of all rooms will be completed using new Room Inspection Form to insure compliance (See attached M-1). C. Bi-monthly room inspections were added to our electronic Preventive Maintenance System-Worx Hub- which will automatically create work orders for all rooms on all wings. Lead Maintenance Mechanic and Director to review work orders on a monthly basis. In-service for existing staff will be completed by the Director of Community Works by 4/29/16 and will be given to all new staff upon hire and repeated at least annually. D. PM System-Worx Hub-will create completed work order reports which will be monitored by Lead Maintenance Mechanic and Director and reported on at weekly management meetings for two months, then monthly for 4 months, then quarterly for two quarters, for 100% compliance. All related issues will be tracked and trended via our internal QAPI system.		
F 309 SS=E	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 record review and interview, it was	F 309		4/29/2016	

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F 309	<p>Continued From page 10</p> <p>determined that the facility failed to ensure that each resident received and the facility provided 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 3 (R16, R55 and R65) out of 52 Stage 2 Sampled residents. For R16, the facility failed to have evidence of monitoring of a right chest wall dialysis port. For R55, the facility failed to have evidence of Hospice being notified when the resident was prescribed antibiotics for two UTIs. For R65, the facility failed to follow the physician orders related to the bowel protocol on multiple occasions. Findings include:</p> <p>The facility's policy and procedure entitled, "Bowel Management", last revised on 7/20/10, stated, "... Procedure: 1. Review the CNA flow book for an elimination pattern. 2. Administer MOM 30 cc p.o. if no BM after 72 hours (9 shifts). 3. If no BM within 1 shift after MOM, administer Dulcolax suppository PR. 4. If no BM within 1 shift of the suppository administration, administer 1 Fleets enema PR...".</p> <p>1. Review of R65's 2/2016 POS revealed the following orders which had start dates of 9/15/15: - MOM every Tuesday and Friday for constipation; - The bowel protocol as per facility policy of MOM if no BM after 9 shifts, Dulcolax suppository if no BM within 8 hours after the MOM, Fleets enema if no BM within 8 hours after the Dulcolax suppository and call the resident's doctor if there were no results after the Fleets enema.</p> <p>The Quarterly MDS assessment, dated 11/30/15, stated R65 was severely cognitively impaired and</p>	F 309		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2016
NAME OF PROVIDER OR SUPPLIER MILTON & HATTIE KUTZ HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 704 RIVER ROAD WILMINGTON, DE 19809	
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F 309	<p>Continued From page 11 had an active diagnosis of constipation.</p> <p>R65 had a potential for constipation care plan that was last revised on 12/22/15. Interventions included medications as ordered and to record BMs every shift.</p> <p>Record review revealed the following regarding R65's bowel protocol was not followed as per the plan of care including physician orders:</p> <ul style="list-style-type: none"> - R65 had a medium BM per the EMR, Bowel Elimination report on 11/12/15. Review of the 11/15 MAR revealed R65 incorrectly received a fleets enema on 11/13/15. - R65 had a small BM per the EMR, Bowel Elimination report on 11/21/15. Review of the 11/15 MAR revealed R65 incorrectly received a Dulcolax suppository on 11/23/15. - R65 had medium and large BMs per the EMR, Bowel Elimination report on 11/23/15 and as of 11/27/15 had had no BMs for 11 shifts. Per the 11/15 MAR, R65 was given prn MOM on 11/27/15 at 1:14 AM and a Dulcolax suppository on 11/27/15 at 1:45 PM. The Dulcolax suppository was noted as "E", referring to the result being effective, however, no BM was entered on the EMR. Also, on 11/29/15 at 2:10 AM, R65's NN stated, "Resident triggered for no bowel movement in 3 days however report from CNA states resident moved bowel on 11/28/15...". The EMR failed to note the 11/28/15 BM. - R65 had not had a BM since 11/28/15, until the resident had a large BM on 12/3/15, 13 shifts. Per the 12/15 MAR, the facility failed to initiate the bowel protocol after 9 shifts. Additionally, R65 	F 309		

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F 309	<p>Continued From page 12</p> <p>received no prn MOM and was given a Dulcolax suppository which was administered on 12/3 and was noted as "E", effective.</p> <p>- R65 had 2 small BMs per the EMR, Bowel Elimination report, one on 12/9/15 and the second on 12/10/15. Per the 12/15 MAR, R65 incorrectly received a Dulcolax suppository on 12/11/15, again, not according to the BM protocol.</p> <p>- R65 had 1 medium BM on 12/20/15 and had no BM for 12 shifts until prn MOM was initiated on 12/24/15 at 8:39 AM. On 12/24/15 at 8:29 PM, R65 was given a Dulcolax suppository was that noted as "I", ineffective. Per the 12/15 MAR, the bowel protocol was not followed as ordered since there was no Fleets enema administered and on 12/25/15, R65 incorrectly received prn MOM at 6:49 PM in addtlion to the scheduled MOM at 8 PM.</p> <p>- R65 had 1 small and 1 medium BMs per the EMR, Bowel Elimination report on 1/10/16, and on 1/14/16 at 11:20 PM, received prn MOM which noted "E" as effective, but, no BM was entered on the EMR. Per the NN, dated 1/15/16 at 06:01 AM, the MOM administered was effective. However, again, it was not recorded in R65's EMR on 1/15/16. Per 1/16 MAR, R65 was incorrectly administered a Dulcolax suppository on 1/16/16 at 3:55 PM, with result of "I", ineffective, and also incorrectly administered a fleets enema on 1/17/16 at 6:21 AM with result of "E" and per EMR, a medium BM was recorded.</p> <p>The facility failed to follow R65's plan of care including physcian orders related to the bowel protocol including:</p> <p>- Failure to record BMs on the EMR which</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>resulted in the bowel protocol incorrectly being inflated;</p> <ul style="list-style-type: none"> - Failure to initiate the bowel protocol after 9 shifts or 72 hours; - Failure to follow the BM protocol orders, beginning with MOM and if ineffective, a Dulcolax suppository and if ineffective a Fleets enema. <p>On 2/29/16 from 4:09 PM through 4:40 PM, E2 (DON) confirmed the findings.</p> <p>2. R16 was re-admitted to the facility, post hospitalization, on 12/24/15.</p> <p>A nurse's note, dated 12/24/15 and timed 11:40 PM, stated "Resident arrived by ambulance...has a RT chest wall dialysis port...".</p> <p>A care plan for the problem potential for alteration in skin integrity, revised 12/24/15, stated R16 had a R chest wall dialysis port and to keep the port clean and dry.</p> <p>Review of R16's hard copy and EMR from 12/25/15 through 3/1/16, lacked evidence of any monitoring of the R chest wall dialysis port, not only to ensure it was clean and dry, but also to monitor for bleeding, pain, and any signs or symptoms of infection.</p> <p>On 3/1/16 at 2:53 PM, during an interview with E2, findings were reviewed. E2 agreed there was no evidence that the R chest wall dialysis port was being monitored for bleeding, pain, or any signs or symptoms of infection and she agreed that staff should be doing this monitoring.</p> <p>3. R55 has received hospice services since she was admitted to the facility on 9/16/14.</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>R55's hospice care plan, last revised on 9/14/15, stated to notify hospice with any changes.</p> <p>An observation on 3/1/16 at 10:41 AM revealed a Hospice sticker on the outside of R55 clinical record. The sticker stated to "notify hospice for any of the following reasons: ... 2. Change in patient's status. 3. Change in prescriptions. 4. Before ordering ... drugs ...".</p> <p>R55 was ordered antibiotic medications for two UTIs on 8/7/15 and 2/26/16. Review of the clinical record lacked evidence that the facility communicated with hospice regarding the new orders for the antibiotics.</p> <p>In an interview on 3/2/16 at 11:26 AM, H1 (hospice LPN) stated that he became aware of R55's 2/26/16 physician's order for antibiotic medication on 2/29/16, three days later.</p> <p>The facility failed to notify hospice of R55's medication changes according to her hospice plan of care when she was prescribed antibiotics for UTIs on 8/7/15 and 2/26/16. Findings were confirmed with E3 (ADON) on 3/2/16 at 12:35 PM.</p>	F 309		
F 314 SS=E	<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</p>	F 314		

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F 314	<p>Continued From page 15</p> <p>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 and interview, it was determined that the facility failed to ensure that two (R13 and R47) residents having pressure sores, out of 52 Stage 2 sampled residents, received the necessary care and services to promote healing and prevent new sores from developing. R13 had a re-opened stage 4 sacral pressure sore and was totally dependent of staff for bed mobility including all ADLs. R13 failed to receive the proper care and treatment as necessary related to turning and positioning in accordance with the facility's standard and plan of care. For R47, the facility failed to complete accurate weekly wound assessments of the left heel PU on multiple occasions. Findings include:</p> <p>1. According to R13's annual MDS assessment, dated 1/4/16, R13 had diagnoses that included Lewy Body Dementia and Parkinson's disease. His cognitive skills in daily decision-making were severely impaired. R13 was totally dependent on staff for bed mobility and in all ADLs.</p> <p>The facility developed a care plan entitled, "Potential for alteration in skin integrity related to decline in bed mobility, incontinent of bowel and bladder" which was dated 10/25/15 and last revised on 2/16/16. The care plan stated that R13 was a high risk for developing a pressure sore, had a Stage 4 sacral pressure sore on 4/9/13 that healed on 4/21/15, and on 9/30/15 the stage 4 sacral pressure sore reopened.</p>	F 314	<p>F 309 Example #1</p> <p>A. Resident R65 bowel medications were reviewed new physician orders received to add routine Miralax on 3/24/2016(see attached N-1) and lactulose on 3/25/2016.(see attached N-2). Resident did not suffer any adverse reactions. Can not correct past practice related to failure to follow physician orders for R65 related to the bowel protocol.</p> <p>B. All residents were reviewed to ensure that physicians orders related to the bowel protocol were being followed accurately.</p> <p>C. We have implemented and all nurses have been in-serviced by the staff educator or designee, on the use of a new Complex Alert Documentation Report (See attached N-3), that shows all residents who trigger to have not had a bowel movement in 3 days directly from CNA's documentation in Point Click Care so as to initiate physicians orders and follow through with the bowel protocol. In-serving will be ongoing upon orientation for any new hires and at least annually during Mandatory Review.</p> <p>D. Unit Managers or designee will monitor and track the Complex Alert Documentation Report daily until 100% compliance is achieved that physicians orders related to the bowel protocol are being followed x 4 consecutive weeks then once a week each month until 100% compliance is achieved x 4 months and then quarterly until 100%compliance is achieved x 2 quarters. Results will be reported monthly at QAPI meetings for continued reassessment and monitoring for compliance.</p>	4/29/2016	

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F 314	<p>Continued From page 16</p> <p>The care plan interventions included, incontinent care at least every 2 hours and prn with skin checks; offload heels on pillows every shift; low air loss mattress; turn and reposition resident every 2 hours, with pillows to offload sacrum.</p> <p>The facility's policy entitled, "Turning Residents", stated, "...to turn and reposition residents so as to provide comfort, prevent skin irritation and breakdown and to promote good body alignment...18. Place pillows behind the resident's back to keep his body in proper alignment...Position the resident's arms and legs in a comfortable position and free from pressure; Place a pillow between the resident's knees if this is comfortable to him".</p> <p>On 2/29/16 at approximately 2:50 PM, in an interview, E13 (CNA), the assigned caregiver for R13, stated R13 was scheduled to be turned on his side at 3:00 PM. At 3:00 PM, E13 was overheard by the surveyor telling E14 (RN) that R13 had been turned on his side.</p> <p>On 2/29/16 at 3:15 PM, the surveyor went to R13's room and found R13 was laying on his back and his right upper body was laying against one pillow (used to support resident's back while on his left side). The one pillow found on R13's back was not enough to support R13 to keep him turned onto his left side and to offload his back and sacrum. At the surveyor's request, E14 (RN) and E15 (LPN) appropriately repositioned R13.</p> <p>On 3/1/16 at 3:15 PM, R13 was observed laying on his back with his right upper back against one pillow and sacrum against the mattress, not offloaded. Surveyor requested E16 (CNA), the</p>	F 314	<p>F 309 Example #2</p> <p>A. Resident R16 received a new order to check the right upper chest wall dialysis access port for signs and symptoms of infection, any bleeding and to ensure that the dressing is clean, dry and intact every shift on 3/1/2016. (see attached N-4). Resident did not suffer any adverse reactions.</p> <p>B. No other dialysis residents in the facility.</p> <p>C. We have implemented and the staff educator or designee will in-service all nurses by 4/29/16 then upon orientation of new hire and at least annually during Mandatory Review on the use of the new electronic order template on PCC(Point Click Care), for care of dialysis access ports to include monitoring of the access port every shift. (see attached N-5). In addition a new category for dialysis has been added for discussion on weekly SWIFT(Skin Wounds Infections Falls Toileting) meetings agenda to review the plan of care for any dialysis residents.(see attached N-6)</p> <p>D. Unit Mangers or Designee will audit and review all new dialysis residents orders upon admission and all current dialysis residents daily until 100% accuracy is achieved that orders to include the care and monitoring of the dialysis port access is initiated and followed through on x 4 consecutive weeks, then until 100%accuracy is achieved weekly x 4 months, then until 100% accuracy is achieved quarterly x 2 quarters. Results will be discussed and reported at weekly SWIFT meetings and monthly QAPI meetings for continued reassessment and monitoring for compliance.</p>	4/29/2016

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F 314	<p>Continued From page 17 assigned caregiver, to check on this resident's position. Upon seeing the way R13 was laying on his bed, E16 stated to the surveyor, " I think I need another pillow, the one pillow was not supporting him".</p> <p>The facility failed to ensure that R13 was turned and repositioned with proper support, proper body alignment, proper sacrum offloading and free from pressure with a pillow between the resident's knees for comfort to promote good body alignment and to promote healing in accordance with facility's standard and care plan.</p> <p>This finding was reviewed with E2 (DON) on 3/2/16 at approximately 1:00 PM.</p> <p>2. Review of the clinical record for R47 revealed:</p> <p>R47 was re-admitted to the facility, post hospitalization, on 11/10/15.</p> <p>1/5/16 - The facility's Skin Alteration Record stated R47 had a left heel PU: - measuring 3cm x 2.5cm x 0.3cm (length by width by depth); - staged as sDTI; - description stated eschar present.</p> <p>1/12/16 - Skin Alteration Record stated left heel PU: - measured 3.6cm x 1.5cm x 0.3cm; - staged as sDTI; - description stated eschar present.</p> <p>1/19/16 - Skin Alteration Record stated left heel PU: - measured 2.5cm x 2.0cm x 0.3cm; - staged as sDTI;</p>	F 314	<p>F309 Example #3 A. Resident R55 hospice was notified about prior antibiotic ordered on 8/7/15 and 2/26/16, on 4/1/2016. Late entry progress note was written by nurse.(see attached N-7). Resident did not suffer any adverse reactions. B. All hospice residents charts have been audited to ensure hospice was notified of any new orders. Have implemented a new electronic order template on PCC and initiated on all hospice residents orders to include notification to hospice of all new orders. (see attached N-8). C. Staff educator or designee will in-service all nurses on the use of the new electronic order template On PCC by 4/29/16 and all new nurses upon hire in orientation and at least annually during Mandatory Review on the initiation of the new order template to notify hospice of new orders. In addition a new category for hospice has been added for discussion on weekly SWIFT meetings agenda.(Refer to attachment N-6). D. Night shift charge nurse or designee will monitor and audit all hospice residents orders to ensure hospice is notified of all new orders daily until 100% compliance is achieved x12 weeks, then monthly until 100% compliance is achieved x6 months, then quarterly until 100% compliance is achieved x2 quarters. Results will be reported at monthly QAPI Meetings for continued reassessment and monitoring for compliance.</p>	4/29/2016
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F 314	<p>Continued From page 18</p> <p>- description stated eschar present.</p> <p>1/26/16 - Skin Alteration Record stated left heel PU: - measured 2.5cm x 1.0cm x 0.2cm; - staged as sDTI; - description stated eschar present.</p> <p>2/3/16 - Skin Alteration Record stated left heel PU: - measured 2cm x 0.5cm x 0.2cm; - staged as s DTI; - description stated eschar present.</p> <p>2/4/16 - Skin Alteration Record stated left heel PU: - measured 2cm x 0.5cm x 0.2cm; - staged as Stage III; - description stated granulation present.</p> <p>The facility failed to accurately assess R47's left heel PU on 1/5/16, 1/12/16, 1/19/16, 1/26/16, 2/3/16 and 2/4/16. A sDTI cannot have depth measured and the presence of eschar would make the wound unstageable.</p> <p>2/8/16 - physician Wound Care Specialist completed an initial evaluation of R47's left heel PU: - measured 2cm x 1.7cm x 0.2cm; - staged as Stage III; - wound bed description was 95% yellow necrotic (slough) and 5% granulation.</p> <p>2/9/16 - in contrast, the facility's Skin Alteration record stated: - measured 2.3cm x 0.6cm x 0.3cm; - staged as Stage III; - description stated granulation present.</p>	F 314	<p>F314 Example #1</p> <p>A. Resident R13 was provided with new sturdy pillows to maintain proper off loading positioning, specialized positioning pillows have been ordered.</p> <p>B. Will assess all residents for positioning needs and provide proper offloading devices as needed.(See attached N-9).</p> <p>C. We have implemented a new assessment tool for turning and repositioning and the staff educator or designee will in-service all nurses by 4/29/16 and all new nurses upon hire in orientation and at least annually during Mandatory Review on how to use the assessment tool for turning and repositioning changes monthly and update plan of care to address any turning and repositioning needs as needed .</p> <p>D. ADON or designee will monitor and audit daily until 100% compliance is achieved x 4 weeks, then weekly until 100% compliance is achieved x 4 months, then quarterly until 100%compliance is achieved x 2 quarters. Results will be reported at weekly SWIFT meetings and monthly QAPI meetings for continued reassessment and monitoring of compliance.</p>	4/29/2016	

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F 314	<p>Continued From page 19</p> <p>2/15/16 - physician Wound Care Specialist evaluation: - measured 1.7cm x1.6cm x0.2cm; - staged as Stage III; - wound bed description was 75% yellow necrotic (slough) and 25% granulation.</p> <p>2/16/16 - in contrast, the facility's Skin Alteration record stated: - measured 2.0cm x 0.3cm x 0.4cm; - staged as Stage III; - description stated granulation present.</p> <p>2/22/16 - physician Wound Care Specialist evaluation: - measured 1.6cm x1.1cm x0.2cm; - staged as Stage III; - wound bed description was 80% yellow necrotic (slough) and 40% granulation.</p> <p>2/23/16 - in contrast, the facility's Skin Alteration record stated: - measured 2.3cm x 0.5cm x 0.2cm; - failed to be staged; - description stated granulation present.</p> <p>2/29/16 - physician Wound Care Specialist evaluation: - measured 1.5cm x 0.8cm x 0.2cm; - staged as Stage III; - wound bed description was 50% yellow necrotic (slough) and 50% granulation.</p> <p>3/1/16 - in contrast, the facility's Skin Alteration record stated: - measured 1.6cm x 0.4cm x 0.2cm; - staged as Stage III; - description stated epithelial tissue present.</p>	F 314	<p>F 314 Example #2</p> <p>A. Resident R47 did not suffer any adverse reactions. Can't correct past practices.</p> <p>B. The facility has now implemented nursing rounds along side with the wound doctor to ensure that both nursing and the doctor are assessing and measuring wounds using the same measuring tools for consistency of wound measurements.</p> <p>C. Revised the wound care policy.(see attached N-10). Staff educator or designee will in-service all nurses by 4/29/16 and all new nurses upon hire in orientation and at least annually during Mandatory Review on the wound care policy and on making rounds with the wound doctor weekly and using the same measuring tools along side with the wound doctor so as to ensure consistency in assessments and measuring of wounds.</p> <p>D. Unit managers will print, review and cross reference nurses notes with the wound doctors notes until 100% accuracy is achieved on consistent wound assessments and measurements weekly x 12 weeks, and then monthly until 100%accuracy is achieved x 6 months, then quarterly until 100% accuracy is achieved x 2 quarters and ongoing there after. Results will be reported at weekly SWIFT meeting and QAPI meetings for continued reassessment and monitoring for compliance.(See attached N-11).</p>	4/29/2016

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F 314	Continued From page 20 The facility continued to inaccurately assess R47's left heel PU despite having a physcian wound care specialist evaluating the PU weekly. During an interview with E2 on 3/2/16 at 12:18 PM, findings were reviewed and confirmed.	F 314																							
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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain safe water temperatures for bathrooms (401, 404, 507, 601, and 606/608 suite) and failed to ensure the building was free from accident hazards in three rooms (103, 207 and 408) out of 30 rooms. Findings Include: 1. On 2/24/16 at 10:08 AM, hot water temperatures in resident's bathroom sinks exceeded 120 degrees Fahrenheit (F) as follows:	F 323																							
	<table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Room</th> <th>Temperature</th> </tr> </thead> <tbody> <tr> <td>2/24/16</td> <td>10:08 AM</td> <td>401</td> <td>120.6 F</td> </tr> <tr> <td>2/24/16</td> <td>10:41 AM</td> <td>404</td> <td>121.1 F</td> </tr> <tr> <td>2/24/16</td> <td>10:41 AM</td> <td>601</td> <td>120.4 F</td> </tr> <tr> <td>2/24/16</td> <td>10:41 AM</td> <td>601</td> <td>121.4 F</td> </tr> </tbody> </table>	Date	Time	Room	Temperature	2/24/16	10:08 AM	401	120.6 F	2/24/16	10:41 AM	404	121.1 F	2/24/16	10:41 AM	601	120.4 F	2/24/16	10:41 AM	601	121.4 F				
Date	Time	Room	Temperature																						
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F 323	<p>Continued From page 21 (rechecked)</p> <p>On 2/24/16, two surveyors tested 12 sinks from rooms (303, 306, 404, 405, 411, 501, 507, 601, 602, 606/608 suite, 300 wing shower room, and 600 shower room) between 1:45 PM and 2:35 PM for unsafe temperatures. This was done by running the hot water for over 3 minutes while recording the highest temperature using separate thermometers. During the test, 3 rooms (507, 601 and 606/608 suite) had temperatures exceeding 120 F.</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Time</th> <th>Room</th> <th>Surveyor1/Surveyor 2</th> </tr> </thead> <tbody> <tr> <td>2/24/16</td> <td>1:46 PM</td> <td>601</td> <td>121.5 F / 121.9 F</td> </tr> <tr> <td>2/24/16</td> <td>1:54 PM</td> <td>606/608</td> <td>123.0 F / 123.5 F</td> </tr> <tr> <td>2/24/16</td> <td>2:15 PM</td> <td>507</td> <td>122.0 F / 122.0 F</td> </tr> </tbody> </table> <p>An interview with E11 (AFMD) revealed that the facility had received complaints about the water being too cold in the previous months. E11 stated the facility was having difficulty maintaining water temperatures due to the one pump water system utilized throughout the building. Heavy hot water usage from one side of the wing could significantly lower the temperature on the opposite side. E11 also revealed that the facility was using a manual mixing valve that required facility maintenance workers to adjust water temperatures manually in the basement. Maintenance kept a daily log of water temperatures and frequently readjusted the valve based on the temperature gauge. The facility had a plumbing company come to the facility 6 times from April 2015 until present, however, the inconsistent water temperature issue was not resolved. The facility requested a digital hot water mixer, but the order was not placed. E1 (NHA) was interviewed on 2/24/15 at 4:50 PM</p>	Date	Time	Room	Surveyor1/Surveyor 2	2/24/16	1:46 PM	601	121.5 F / 121.9 F	2/24/16	1:54 PM	606/608	123.0 F / 123.5 F	2/24/16	2:15 PM	507	122.0 F / 122.0 F	F 323	<p>F323 Example#1</p> <p>A. No residents were directly affected by this practice. Although hot water temperatures were monitored twice per day, and no irregular temperatures were noted, the mixing valve failed. Immediately upon notification, hot water temperatures were manually adjusted not to exceed 110 degrees. Existing hot water mixing valve was replaced</p> <p>B. by an electronically controlled mixing valve, allowing for more accurate water temperature control and monitoring. New water temperature monitors were installed on hot water piping to better track water temperatures.</p> <p>C. "Date" and "Initial" columns were added to Daily Water Temperature Inspection Log to more accurately track temperature variations (see attached M-2). We are now tracking water temperatures both manually and through new water temperature system. Maintenance Lead assigned, via PM system, to complete weekly QA inspections of Hot Water Temperature Logs to assure compliance.</p> <p>D. PM System-Worx Hub will automatically monitor completion of inspections stated in Section C. Director of Plant Operations and Lead Maintenance Mechanic will review monthly completion reports, via the Worx Hub system, to assure compliance. Director to review all results weekly at weekly management meeting for 8 weeks then monthly for 4 months and then quarterly for 2 quarters, for 100% compliance. Results will also be tracked and trended in our internal QAPI process.</p>	4/29/2016	
Date	Time	Room	Surveyor1/Surveyor 2																		
2/24/16	1:46 PM	601	121.5 F / 121.9 F																		
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F 323	<p>Continued From page 22</p> <p>and corroborated E11's interview. E1 also supplied invoices to support their claims.</p> <p>On 2/29/16 at 9:00 AM, E11 stated that the digital mixer had been installed and further maintenance of the building's hot water system will be ongoing.</p> <p>Findings were reviewed with E1, E2 (DON) and E3 (ADON) on 3/2/16 at approximately 4:30 PM.</p> <p>2. During the environmental tour on 3/1/16 between 9:45 AM and 10:30 AM with E10 (FMD) revealed the following:</p> <p>a. Towel bar was loose from wall in bathroom of room 103.</p> <p>b. Attached toilet seat handrails were loose in bathroom of room 408.</p> <p>c. Cable cord running between dresser and window was a potential tripping hazard in room 207.</p> <p>Findings were reviewed and confirmed with E10 during the environmental tour.</p> <p>Findings were reviewed with E1, E2 and E3 on 3/2/16 at approximately 4:30 PM.</p>	F 323	<p>F 323 Example #2</p> <p>A. No residents were directly affected by this practice. All of the following identified items have been addressed:</p> <ul style="list-style-type: none"> • Towel bar in 103 repaired • Toilet seat rails in room 408 replaced. • Cable cord in room 207 was secured-2/26/16 <p>B. An audit of all rooms will be completed using new Room Inspection Form to insure compliance. (See attached M1).</p> <p>C. Bi-monthly room inspections were added to our electronic Preventive Maintenance System-Worx Hub- which will automatically create work orders for all rooms on all wings. Lead Maintenance Mechanic and Director to review work orders on a monthly basis. In-service for existing staff will be completed by the Director of Community Works by 4/29/16 and will be given to all new staff upon hire and repeated at least annually.</p> <p>D. PM System-Worx Hub-will create completed work order reports which will be monitored by Lead Maintenance Mechanic and Director and reported on at weekly management meetings for two months then monthly for 4 months, then quarterly for two quarters, for 100% compliance. All related issues will be tracked and trended via our internal QAPI system.</p>	<p>3/22/2016</p> <p>3/22/2016</p> <p>3/22/2016</p>
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of</p>	F 329		4/29/2016

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F 329	<p>Continued From page 23</p> <p>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 clinical record review and interview, it was determined that for one (R55) out of 52 Stage 2 sampled residents, the facility failed to maintain R55's drug regimen was free from unnecessary drugs when she was prescribed two rounds of antibiotics for two UTI's on 8/17/15 and 11/9/15 without adequate clinical indications for use. Findings include:</p> <p>R55 was admitted to the facility on 9/16/14 with a history of UTI's and currently was receiving hospice services.</p> <p>a) Review of R55's clinical record revealed an undated facility form entitled "Urinary Tract Infections" which stated, "... the resident must have 3 of the following symptoms:</p>	F 329	<p>F 329</p> <p>A. Although resident R55 had signs and symptoms of infection, documentation was unclear. Resident R55 did not suffer any adverse reactions. Can not correct past practices. Resident has currently no signs and symptoms or any clinical indications suggestive of an active infection. The new reference guide has been implemented for R55 and all other residents.</p> <p>B. Will review all the residents on antibiotics to ensure adequate documentation of clinical indications for use.</p> <p>C. The facility has implemented the use of a new reference guide for documentation on clinical indications for antibiotic use that will act as a reference guide and assist nurses in their assessments and documentation. The staff educator or designee will in-service all nurses by 4/29/16 and all new nurses upon hire in orientation and at least annually during Mandatory Review on the use of the reference guide.(see attached N-12).</p> <p>D. Infection Control/Preventionist nurse or designee will monitor and review documentation for all residents on antibiotics until 100% accuracy is achieved on the documentation of clinical indications weekly x 12 weeks, then monthly until 100% accuracy is achieved x 6 months and then quarterly until 100% accuracy is achieved x 2 quarters.(see attached N-13). Results will be reported at weekly SWIFT meetings and monthly at QAPI meetings for continued reassessment and monitoring for compliance.</p>	4/29/2016	

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F 329	<p>Continued From page 24</p> <ul style="list-style-type: none"> - fever (> or = 100.4 F) or chills; - new or increased burning pain on urination, frequency or urgency; - new flank or suprapubic pain; - change in character of urine (new bloody, foul odor, etc) OR lab report ... of new pyuria or microscopic hematuria ...; - worsening of mental or functional status ...". <p>A physician's order, dated 8/14/15, stated to perform an urinalysis and urine culture.</p> <p>The 8/17/15 progress note stated R55 was experiencing dysuria.</p> <p>Review of the nurse's notes from 8/11/15 through 8/17/15 lacked evidence of additional UTI symptoms exhibited by R55.</p> <p>The 8/17/15 UA C&S lab result stated that her urine revealed the absence of an infective organism.</p> <p>A telephone physician's order, dated 8/17/15, stated that R55 was prescribed Bactrim, an antibiotic, twice a day for 3 days for diagnosis of bacteriuria.</p> <p>b) A social services note, dated 11/3/15 timed 4:17 PM, stated that R55's relative told E5 (SSD) that R55 complained of burning, urinary frequency, headaches and disjointed conversation. The note also stated that R55 can be confused and anxious and nursing would note her symptoms in the doctor's book and contact hospice to evaluate her anxiety.</p> <p>A nurse's note, dated 11/5/15 timed 3:40 AM, stated that R55's urine specimen was slightly</p>	F 329		

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F 329	Continued From page 25 cloudy yellow. R55's urinalysis result, dated 11/5/15, stated that the urine was clear yellow despite the 11/5/15 nurse's note stating R55's urine was slightly cloudy yellow. The 11/7/15 UA C&S lab result stated that R55's urine had an infective organism. A nurse's note, dated 11/7/15 timed 5:11 PM, stated that UA C&S results were received and the physician notified. The note also stated that R55 was asymptomatic and there were no new orders by the physician. Review of R55's nurse's notes from 11/7/15 through 11/9/15 lacked evidence of UTI symptoms exhibited by R55. A nurse's note, dated 11/9/15 timed 3:52 PM, stated that R55's UA C&S lab result was reviewed by a different physician and R55 was prescribed Macrobid, an antibiotic, twice a day for 7 days for a UTI. A nurse's note, dated 11/9/15 timed 10:26 PM, stated that R55 received her first antibiotic dose around 5:00 PM. The note also stated that R55 was voiding without difficulty, denied pain and exhibited no confusion. The facility prescribed antibiotics to R55 for UTI's on 8/17/15 and 11/9/15 without adequate clinical indications for use. In an interview on 3/2/16 at 12:35 PM, E3 (ADON) confirmed the findings.	F 329			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	Continued From page 26 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to distribute and serve food under sanitary conditions. Findings include: During a lunch observation on 2/23/16 at 12 PM, E12 (dietary aide) delivered an open cart of food trays to the satellite dining room. As E12 parked the cart, a plate cover fell off of one plate and rolled onto the carpeted floor. E12 then picked up the cover from the floor, replaced it onto the plate of food and left the dining room. The surveyor advised another staff member in the dining room of what happened and requested that the plate of food be replaced and it was. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/2/16 at approximately 4:15 PM during the exit conference.	F 371	F 371 A. This resident food tray was taken away and replaced with a new food tray. No resident was adversely affected by this practice. B. Employee (E-12) was immediately disciplined and educated on Infection Control and practices regarding food handling, storage and delivery. Dining Services Director or Designee will shadow Dietary Aides during delivery to ensure that safe food handling practices are being followed. C. To insure proper Infection control practices are followed on an ongoing basis, food cart delivery compliance will now be included on the Meal Evaluation form(see attached D-2). The Meal Evaluation form will be completed weekly by a Dining Services supervisor. All Dining Services staff will be re-in serviced on Infection control policy and practices regarding food handling, storage and delivery (see attached D-3), and the use of the Meal Evaluation form. Director of Dining Service will provide this in-service training to existing staff by April 29, 2016, and upon hire for new staff and at least annually D. As part of the Meal Evaluation, food cart delivery will be monitored by Dining Service management team every two weeks for 2 months, then monthly for 3 months, then quarterly for 12 months for 100% compliance. Results will be reported at the monthly QAPI meetings for 12 months for evaluation,	4/29/2016	
F 441 SS=D	483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	discussion, and program compliance		

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F 441	<p>Continued From page 27</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Cross-refer to F314 example 1 Based on observation, Interview and record</p>	F 441	<p>A. Resident R13 did not suffer any adverse reactions. Can not change past practices. Nurse E-15 was in-serviced on hand washing and demonstrated competency. (See attached N -14). Unit manager or designee will accompany treatment nurse during treatments to ensure that proper hand washing procedures are being followed.</p> <p>B. Staff educator or designee will re-in service all nursing staff by 4/29/16 and all new nurses upon hire in orientation and at least annually on Mandatory Review on hand washing procedures according to acceptable professional practice.</p> <p>C. Infection Control/Preventionist nurse or designee will complete hand washing procedures competencies and gloving competency (See attached N-14a) upon new hire and at least annually during Mandatory Review on all nursing staff and on going monitoring and competencies monthly.</p> <p>D. Infection Control/Preventionist nurse or designee will perform competencies until 100% compliance is achieved of 20% nursing staff at random weekly x 4 weeks, 4/29/2016 then until 100% compliance is achieved monthly x 4 months, and then until 100% compliance is achieved quarterly x 2 quarters. Results will be reported at weekly SWIFT meetings and monthly QAPI meetings for continued reassessment and monitoring for compliance.</p>	4/29/2016

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F 441	Continued From page 28 review, it was determined that the facility failed to ensure that staff washed their hands after each direct resident contact for which hand washing was indicated by accepted professional practice for one (R13) out of 52 Stage 2 sampled residents. Findings include: On 2/26/16 at approximately 10:15 AM, during a dressing change and treatment of R13's sacral wound, it was observed that E15 (LPN) washed hands, donned a pair of clean gloves and removed the soiled dressing from the sacral pressure ulcer. After removal of the soiled dressing, E15, without handwashing and donning a pair of clean gloves, used the same contaminated gloves to provide the treatment. This included cleansing of the wound with normal saline solution, touching a clean 4x4 gauze to wipe the saline drips twice and then applying the Nystatin ointment to the wound with the same contaminated gloves. This finding was reviewed with E15 and E2 (DON) on 2/26/16 at approximately 10:30 AM.	F 441			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide or obtain laboratory services in an accurate and timely manner to meet the needs of one (R59)	F 502			

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NAME OF PROVIDER OR SUPPLIER MILTON & HATTIE KUTZ HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 704 RIVER ROAD WILMINGTON, DE 19809		
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F 502	<p>Continued From page 29 out of 52 Stage 2 sampled residents. Findings include:</p> <p>Review of physician orders revealed that R59 was prescribed Lipitor daily for hyperlipidemia. According to a consultant pharmacist recommendation, dated 10/23/15, R59 should be tested for LFT's and a lipid profile. E8 (Medical Director) agreed with the pharmacist's recommendation and E8 signed and dated his response on 10/23/15. Review of R59's medical record lacked LFT's, however, there was a lipid profile.</p> <p>E3 (ADON) was interviewed on 2/25/16 at approximately 3:00 PM and confirmed the absence of LFT's in R59's medical record. E3 then obtained R59's laboratory records from Brookside Clinical Laboratory that were ordered on 11/17/15. According to the lab record, only a BMP and lipid profile were collected.</p> <p>E2 (DON) was interviewed on 2/29/16 at 2:30 PM and confirmed that a BMP was mistakenly ordered by the 11 PM - 7 AM nurse, instead of a CMP, which includes LFT's.</p> <p>Findings were reviewed with E1 (NHA), E2 and E3 on 3/2/16 at approximately 4:30 PM.</p>	F 502	<p>F 502</p> <p>A. Resident R59 had CMP (comprehensive metabolic panel) completed on 2/26/2016. Resident did not suffer any adverse effects. Liver Function Test and Lipid Profile Panel within normal limits. (see attached N-15).</p> <p>B. Reviewed all resident lab orders for accuracy to ensure that the labs drawn were the labs ordered as per physicians orders.</p> <p>C. In the process of integrating PCC with Brookside Lab to ensure accuracy with doctors lab orders. In addition, the staff educator or designee will in service the nurses by 4/29/16 to continue to complete lab order sheets and reference back to the doctors orders for accuracy before the labs are drawn. Upon integration, the staff educator or designee will in-service all nurses on the integration with brookside lab and checking the lab orders to ensure they accurately match the lab sheets.</p> <p>D. The Unit managers or designee will monitor that the labs ordered match the labs drawn until 100% accuracy is achieved daily x 4 weeks, then until 100% accuracy is achieved weekly x 4 months, then until 100% accuracy is achieved quarterly x 2 quarters. Results will be reported to weekly SWIFT meetings and QAPI monthly for continued reassessment and monitoring for compliance. (see attached N-16).</p>	4/29/2016	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: The Milton & Hattie Kutz Home

DATE SURVEY COMPLETED: March 2, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual recertification survey was conducted at this facility from February 23, 2016 through March 2, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 87. The Stage 2 survey sample size was 52.</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 March 2, 2016 F241, F253, F309, F314, F323, F329, F371, F441, and F502.</p>	<p>Cross refer to F 241, F 253, F 309, F 314, F 323, F 329, F 371, F 441, and F 502</p>	<p>4/29/2106</p>

Provider's Signature  Title EXECUTIVE DIR. Date 4/8/16