

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

PRINTED: 12/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/15/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILTON &amp; HATTIE KUTZ HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>704 RIVER ROAD WILMINGTON, DE 19809</b>	
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F 000	INITIAL COMMENTS  An unannounced annual survey was conducted at this facility from 12/1/14 through 12/15/14. 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 83. The Stage 2 survey sample size was 33.  Abbreviations used in this 2567 are as follows:  NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; UM - Unit Manager; DCW - Director of Community Works; MAR - Medication Administration Record; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); MRR - Medication Regimen Review; POS - Physician Order Sheet/Doctor's orders; SSD - Social Services Director; DDS - Director of Dining Services; ROM-Range of Motion; BIMS-Brief Interview for Mental Status.	F 000		
F 170 SS=B	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL  The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.	F 170		

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*EXECUTIVE DIRECTOR*

*1-8-15*

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 170	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility mail delivery system, it was determined that the facility failed to provide mail delivery to residents on Saturdays. Findings include:  On 12/3/14 at 2:00 PM, an interview with R44 revealed that residents do not receive mail on Saturdays. R44 stated that during the week mail is delivered to your room, but if mail comes on Saturdays, it is delivered to the front desk. R44 stated that unless she went to the front desk on Saturdays, she would not get Saturdays mail until Monday.  During an interview on 12/9/14 at 9:30 AM with E20 (Receptionist), a 10 year employee of the facility, she stated that the mail delivery system has been the same since she has been here. E20 works Monday-Friday 8 AM - 4:30 PM, and on the weekend various part-time staff work from 8 AM - 8 PM. E20 stated that mail is delivered once a day to the facility from Monday to Saturday. When asked by the surveyor what the normal routine was once mail was delivered to the facility, E20 stated that she sorts out the mail. She then places resident mail into a bin and then someone from the activities department picks up the mail from the bin and delivers it to the residents. E20 stated on Saturday there were no activity personnel in the facility, so mail is not delivered to the residents until Monday.  The facility's mail delivery system failed to ensure residents received mail on Saturdays.	F 170	A. Unable to correct past practices  B. All residents are now receiving mail Monday through Saturday  C. A new policy has been developed which includes the sorting of mail by the receptionist and distribution by nursing staff on weekends. (see attached A-1). Activities staff will continue to deliver mail on weekdays. All receptionists and Nursing supervisors will be inserviced on this protocol. In addition, the Shift supervisor will monitor this practice as part of the Shift Supervisor report (see attached N-21)  D. The receptionist will monitor daily for 100% compliance on any ongoing basis. Results presented at the monthly QAPI meeting by the Executive Director	1-26-15	

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F 170 F 241 SS=E	Continued From page 2 Findings were reviewed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:20 PM. 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 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 for five (R23, R33, R37, R66 and R68) out of 33 Stage 2 sampled residents. For R23, R33, R66 and R68 the facility failed to maintain residents' dignity when observations were made of staff entering residents' rooms without knocking and/or asking permission to enter. For R37 the facility failed to maintain residents' dignity when observations were made of these residents having clothing protectors placed on them without asking if they wanted the protectors. Findings include:  The facility's "Resident Rights" policy, last revised in 6/2012, stated, "... Every resident has the right of privacy in his/her room, and personnel of the facility shall respect this right by knocking on the door before entering the resident's room...".  1. On 12/2/14 at 12:09 PM and at 12:12 PM respectively, observations were made of E18	F 170 F 241	A. Unable to correct past practices  B. Example #1 All facility and Medical staff will be re-in-serviced on proper procedure for entering resident rooms Example #2 All facility staff will be re-inserviced on resident dignity in the dining room, which includes asking permission for the use of clothing protectors.  C. The Residents Rights section of the Employee Manual has been revised to emphasize privacy and dignity issues (see attached relevant page A-2) The Nursing Supervisors will monitor compliance, and document on the Supervisor Shift Report (see attached N-21). Nursing Supervisor will be inserviced on the modifications to the form and the related requirements		

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F 241	<p>Continued From page 3</p> <p>(CNA) entering R66's room without knocking or asking permission to enter. R66 was speaking with the surveyor and the resident was seated in a wheelchair with her back to the doorway at the above mentioned times.</p> <p>On 12/2/14 at 12:15 PM, in an interview, E18 confirmed that she did not knock or ask permission to enter R66's room when answering the resident's call light either time.</p> <p>2a. During an interview on 12/1/14 at 11:29 AM, E19 (CNA) knocked and immediately opened R23's door. E19 saw the surveyor and stated that she was looking for another staff member.</p> <p>During an interview, immediately afterwards, E19 confirmed that she had knocked and did not request permission to enter before opening the door. When asked what she was supposed to do, she incorrectly stated that staff were to knock and announce themselves. She denied having to ask permission to enter a resident's room.</p> <p>2b. During an interview on 12/1/14 at 11:45 AM, E10 (Doctor) opened R23's door without knocking and when she saw the surveyor, stated that she would come back.</p> <p>During an interview on 12/1/14 at 11:50 AM, E10 confirmed that she had knocked but failed to request permission to enter R23's room.</p> <p>2c. On 12/3/14 at 8:35 AM, R23 had her call light on. E12 (CNA) entered R23's room, walked directly to the call bell control panel and turned it off and asked the resident what she needed. E12 failed to knock or ask permission prior to entering R23's room.</p>	F 241	<p>D. The DON or designee will monitor: The Shift Supervisor report daily for 95% compliance for 4 consecutive weeks, THEN, for one week per month for 95% compliance for 3 consecutive months, THEN, once monthly for 95% compliance for 3 consecutive months.</p> <p>Results will be reported at the monthly QAPI meeting.</p>	<b>1/26/15</b>	

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F 241	<p>Continued From page 4</p> <p>Findings were confirmed immediately afterwards during an interview with E12.</p> <p>3. During a resident interview on 12/2/14 at 8:35 AM, E16 (Unit Clerk) knocked and walked into R33's room without asking permission. E16 stated that she was delivering supplies.</p> <p>During an interview on 12/11/14 at 2:37 PM, E17 (LPN) confirmed that staff needed to knock and request permission before entering resident rooms.</p> <p>On 12/11/14 at 2:42 PM, E16 confirmed the findings.</p> <p>4. On 12/1/14 at 11:10 AM, E5 (LPN) knocked and opened R68's door, without waiting for permission to enter, while two surveyors conducted a resident interview.</p> <p>5. During a dining observation on 12/1/14 at 11:52 AM, E22 (CNA) was observed placing a clothing protector on R37 without asking the resident's permission to do so.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:20 PM.</p> <p><b>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and</p>	F 246	<p>A. The missing extension on R64'S over bed light pull cord was installed within 20 minutes of notification.</p> <p>B. Extensions on all residents over bed light pull cords were checked for proper placement</p> <p>C.</p> <ol style="list-style-type: none"> <li>1. The RESIDENT ROOM DISCHARGE CLEANING AND MAINTENANCE PROTOCOLS Policy (see attached M-1 ) has been revised for use by maintenance and housekeeping staff to include the usage of the Internal Rounds Report to ensure the rooms are checked for any deficiencies. All staff have been inserviced on this protocol.</li> <li>2. An Internal Facility Rounds form is in use by the Maintenance Director on random weekly tours in the residential areas</li> <li>3. Monthly Safety Tours will also use the Internal Facility Rounds form (see attached M-2) on all inspections</li> <li>4. In addition, the Nursing Supervisor will monitor and document on the Shift Supervisor report form (see attached N-21)</li> </ol>
F 246 SS=D			

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F 246	Continued From page 5 preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one (R64) out of 33 Stage 2 sampled residents had reasonable accommodations of her needs met. The facility failed to ensure that R64's over bed light pull cord was within reach. Findings include:  An observation on 12/1/14 at 2:30 PM revealed that R64's over bed light pull cord was short and not within reach.  Findings were confirmed during an environmental tour with E7 (DCW) on 12/3/14 at 10:04 AM.	F 246	D. The Maintenance Director reviews the completed reports and work orders on a daily basis. Any work orders received relating to resident over bed light pull cord will be reviewed at weekly management meetings for 8 weeks for 100% compliance, then monthly for 4 months, then quarterly for 2 quarters and reported at monthly QAPI meetings.  F 253  EXAMPLE # 1  A. A new light fixture was installed in R- 109's room  B. All resident rooms have been checked to insure that all overbed fixtures are in good condition  C. 1. The RESIDENT ROOM DISCHARGE CLEANING AND MAINTENANCE PROTOCOLS Policy (see attached M-1) has been revised for use by maintenance and housekeeping staff to include the usage of the Internal Rounds Report to ensure the rooms are checked for any deficiencies. All staff have been inserviced on this protocol.	1/9/15	
F 253 SS=D	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 interview, it was determined for two (R67 and R109) out of 33 Stage 2 sampled residents, the facility failed to maintain room equipment in good repair for a comfortable interior. Findings include:				

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F 253	Continued From page 6 1. An observation of R109's room on 12/1/14 at 10:51 AM revealed a 2-inch split in the over bed light shield.  2. An observation of R67's bathroom on 12/2/14 at 8:51 AM revealed a loose towel bar.  Findings were confirmed during an environmental tour with E7 (DCW) on 12/3/14 from 9:40 AM to 9:46 AM.	F 253	2. An Internal Facility Rounds form (see attached M-2) is in use by the Maintenance Director on random weekly tours in the residential areas 3. Monthly Safety Tours will also use the Internal Facility Rounds form on all inspections		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;		D. The Maintenance Director reviews the completed reports and work orders on a daily basis. Any work orders received relating to a split resident over bed light shield will be reviewed at weekly management meetings for 8 weeks for 100% compliance, then monthly for 4 months, then quarterly for 2 quarters and reported at monthly QAPI meetings.  EXAMPLE #2  A. The towel bar in the bathroom of R 67 was removed and secured tightly to the wall  B. All resident rooms have been checked to insure that all towel bars are secure		

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F 253	Continued From page 6 1. An observation of R109's room on 12/1/14 at 10:51 AM revealed a 2-inch split in the over bed light shield.  2. An observation of R67's bathroom on 12/2/14 at 8:51 AM revealed a loose towel bar.  Findings were confirmed during an environmental tour with E7 (DCW) on 12/3/14 from 9:40 AM to 9:46 AM.	F 253	C. An Internal Facility Rounds form (see attached M-2) is in use by the Maintenance Director on random weekly tours in the residential areas  The RESIDENT ROOM DISCHARGE CLEANING AND MAINTENANCE PROTOCOLS Policy (see attached M-1) has been revised for use by maintenance and housekeeping staff to include the usage of the Internal Rounds Report to ensure the rooms are checked for any deficiencies. All staff have been inserviced on this protocol,  Monthly Safety Tours will also use the Internal Facility Rounds form on all inspections	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized* reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;		D. The Maintenance Director reviews the completed reports and work orders on a daily basis. Any work orders received relating to a resident's bathroom towel bar will be reviewed at weekly management meetings for 8 weeks for 100% compliance, then monthly for 4 months, then quarterly for 2 quarters and reported at monthly QAPI meetings.	1/09/2015

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F 272	<p>Continued From page 7</p> <p>Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to initially and periodically conduct a comprehensive assessment that was an accurate, standardized reproducible assessment of each resident's functional capacity for four (R12, R34, R66 and R77) out of 33 Stage 2 sampled residents. Findings include:</p> <p>The facility's "MDS" policy, last revised in 6/2013, stated, "... Documentation in the resident chart, assessment forms as well as resident assessment will be used to capture current resident status as well as changes in condition..."</p> <p>1. R66 had a nutrition care plan with an interventions for a mechanical soft diet (smoother texture than regular foods; eliminates foods that are difficult to chew or swallow) with nectar thick liquids (thickened liquids can help prevent choking and stop fluid from entering the lungs) which was initiated on 8/12/14 and revised on 9/10/14 and 10/30/14.</p>	F 272	<p>A. Example #1- R66 Correction was made to significant change MDS dated 10/21/14 Example #2- R12 no longer resides in this facility Example #3- R34 Correction was made to significant change MDS dated 9/2/14 Example #4- R77 Correction was made to MDS assessment dated 11/3/14 (See attached N-1, 2, and 3)</p> <p>B. A chart audit will be conducted to insure MDS accuracy with particular focus on Sections K, L, C and G, using the MDS audit tool (see attached N-4)</p>		

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F 272	<p>Continued From page 8</p> <p>On 10/14/14, R66 returned to the facility from the hospital and R66's doctor ordered a mechanical soft diet with thickened liquids and a speech therapy [ST] evaluation and treatment.</p> <p>Review of the Speech Therapy evaluation stated, "10/14/14, Reason for Referral: Patient referred to ST due to exacerbation (worsening) of baseline dysphagia (difficulty swallowing) during recent hospital admission...".</p> <p>R66's significant change MDS, dated 10/21/14, was incorrectly coded for a swallowing disorder as, "none of the above".</p> <p>During an interview on 12/11/14 at 2:45 PM, E4 (RNAC) confirmed that R66 should have been coded as having difficulty swallowing.</p> <p>The facility failed to accurately assess R66's swallowing on the significant change MDS, dated 10/21/14.</p> <p>2. R12 was admitted to the facility on 6/23/14 with a history of dysphagia. On 6/24/14, an initial ST evaluation was done for dysphagia and R12 was consequently ordered a mechanical soft diet.</p> <p>Review of R12's admission/5 day MDS, dated 6/26/14, failed to list a diagnosis of dysphagia and incorrectly listed that R12 had no swallowing problems, despite having a history of dysphagia and confirmation of the diagnosis by ST on 6/24/14.</p> <p>A nurse's note, dated 7/6/14, stated that R12 had a choking episode after a family member brought in and served regular foods to the resident (despite previous discussion with the family</p>	F 272	<p>C. Dietitian, Social Worker and nurses will be inserviced re: RAI manual definitions and directions for completing these sections (K, L, C, and G). Nurses will be inserviced on completing the Oral/Dental status form (see attached N-5). The Dietician and RNAC will be inserviced on correctly coding the MDS in section L based on the dental status report. Oral/Dental status form has been revised for clarity</p> <p>D. The DON or designee will monitor: Weekly: 20% of MDS sections K, L, C, and G will be reviewed for accuracy prior to submission until 100% accuracy is achieved x 4 consecutive reviews, THEN, 20% of MDS sections K, L, C, and G will be reviewed monthly for accuracy prior to submission until 100% accuracy is achieved x 4 consecutive reviews. THEN, 20% of MDS sections K, L, C, and G will be reviewed quarterly for accuracy prior to submission, maintaining 100% accuracy. Results will be reported at the monthly QAPI meeting.</p>	1/26/15

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 272	<p>Continued From page 9</p> <p>member about R12's need for a mechanical soft diet when it was ordered).</p> <p>Review of R12's Medicare/Readmit MDS, dated 7/7/14, revealed that dysphagia was coded, however, the facility failed to identify that the resident was on a mechanically altered diet (ordered on 6/24).</p> <p>Review of the Medicare 30 day MDS, dated 7/28/14, failed to identify and code dysphagia although it was on the 7/7/14 MDS and R12 had a choking episode on 7/8/14.</p> <p>Review of the ST Discharge Summary, dated 7/30/14, stated that R12 required a mechanical soft diet and 24 hour supervision.</p> <p>Findings were confirmed with E4 (RNAC) during an interview on 12/11/14 at approximately 11:30 AM.</p> <p>3a. Review of R34's significant change MDS assessment, dated 9/2/14, incorrectly coded R34 as totally dependent with one person physical assist to walk in her room and in the corridor. The same MDS also incorrectly coded R34 as having no impairment in ROM [the extent to which a joint can be moved safely].</p> <p>During an interview on 12/9/14 at 9:45 AM, E4 (RNAC) stated that R34 was hospitalized around September. E4 stated she had to do a significant change MDS when R34 elected to be on Hospice (service that provides care to residents that are terminally ill) and then had to do another significant change MDS when R34 revoked her</p>	F 272		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 10 decision to be on Hospice.</p> <p>When asked if R34 had ever been ambulatory since her arrival to the facility in 2012, E4 stated that R34 has "never walked". E4 confirmed that on the 9/2/14 significant change MDS, the information was "absolutely wrong." E4 also confirmed the inaccuracy on the significant change MDS dated 9/2/14. E4 stated that as indicated by the ROM Assessment sheet, R34 had a limitation to her left shoulder.</p> <p>3b. Review of R34's significant change MDS assessment, dated 9/8/14, incorrectly listed that R34 was severely cognitively impaired (unable to make own decisions), and scored at a 3. The same MDS also incorrectly coded within the ROM section that R34 had no impairment.</p> <p>During an interview on 12/9/14 at 9:45 AM, interview with E4 confirmed a coding inaccuracy on the 9/8/14 significant change MDS regarding ROM. E4 stated that R34 had limitation to her left shoulder.</p> <p>On 12/9/14 at 10:16 AM, interview with E23 (SSD), confirmed the MDS inaccuracy in the cognition section of the significant change MDS dated 9/8/14. E23 confirmed that R34 should have been coded as a 15 Cognitively Intact.</p> <p>4. Review of R77's annual MDS assessment dated, 11/3/14, incorrectly coded R77 as both edentulous (toothless) and having oblvous or likely cavly or broken natural teeth.</p> <p>On 12/10/14 at 9:49 AM, interview with E24 (Dietician), confirmed the inaccuracy. E24 stated she was responsible for filling out the dental</p>	F 272		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	Continued From page 11 portion of the MDS and stated she was confused on the definition of the word edentulous.		<p><b>F278</b></p> <p>A. R34 Correction made to MDS dated 8/11/14 (see attached N-6)</p> <p>B. A chart audit will be conducted to insure accuracy of the MDSs, with particular focus on Section G, using the MDS Audit tool. (see attached N-4)</p> <p>C. RNAC will be re-inserviced on proper interpretation of the Range of Motion Assessment form and correctly coding Section G of the MDS (see attached form N-7)</p> <p>D. The DON or designee will monitor: Weekly: 20% of MDS section G will be reviewed for accuracy prior to submission until 100% accuracy is achieved x 4 consecutive reviews. THEN, 20% of MDS sections G will be reviewed monthly for accuracy prior to submission until 100% accuracy is achieved x 4 consecutive reviews. THEN, 20% of MDS sections G will be reviewed quarterly for accuracy prior to submission, maintaining 100% accuracy.</p> <p>Results will be reported at the monthly QAPI meeting.</p>		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced</p>				1/26/15

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F 278	Continued From page 12 by: Based on interview and record review, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the resident's status for one (R34) out of 33 Stage 2 sampled residents. Findings include:  Review of R34's quarterly MDS assessment, dated 8/11/14, incorrectly documented within the ROM [the extent to which a joint can be moved safely] section that R34 had no impairment.  On 12/9/14 at 9:45 AM, Interview with E4 (RNAC) confirmed the inaccuracy and stated that R34 had limitation to her left shoulder.  Findings were discussed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:15 PM.		<b>F309</b>  A. Example #1- R23 Unable to correct the past practice at this time. Resident did not suffer any adverse reaction from the practice.  Example #2- R112 Resident is alert and oriented to person, place and time. She is continent of her bowels She declined the bowel medication when it was offered because she had a bowel movement (BM) that day. Resident has been asked daily about her bowel status and has reported having regular BMs. No adverse effects .  B. Example #1-R23 the Medication Errors policy has been revised. When a nurse notes a medication that has not been signed off as administered, he/she will notify the nursing supervisor. The supervisor will implement the revised " Medication Errors" policy, which includes a Medication Error form and an investigation. (see attached N-8). Additionally, during the night shift "chart checks procedure", the nurse will review 100% of the Medication Administration Records		
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 record reviews and interviews, it was determined that for two (R23 and R112) out of 33 Stage 2 sampled residents, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental,				

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F 309	<p>Continued From page 13</p> <p>and psychosocial well-being. The facility failed to follow the plan of care when R23's antibiotic medication (Keflex) dosage was ordered to be administered three times a day for 10 days. The facility failed to administer three doses of Keflex to R23 according to physician's orders. Additionally, the facility failed to follow a physician's order to initiate the bowel protocol for R112. Findings include:</p> <p>1. R23 had a doctor's order, dated 11/10/14, for Keflex 500 milligrams by mouth three times a day for 10 days.</p> <p>Review of R23's November 2014 MAR revealed that the Keflex was timed to be administered at 8 AM, 12 PM and 8 PM. R23 received Keflex from 8 PM on 11/11/14 through 11/20/14 at 12 PM (9 days/27 doses). R23 should have received the Keflex through 11/21/14 (10 days/30 doses).</p> <p>During an interview on 12/4/14 at 11:45 AM, E6 (UM) confirmed the findings. The facility failed to ensure that R23 received her antibiotic as ordered by the physician and per the plan of care.</p> <p>2. R112 was admitted to the facility on 11/19/14.</p> <p>A physician's order, dated 11/19/14, stated to initiate the bowel protocol (medications given for constipation) if no bowel movement (BM) occurred in nine (9) shifts.</p> <p>Review of CNA documentation for R112's bowel elimination revealed the lack of a BM from 11/20/14 at approximately 7:00 AM until 11/24/14 at 12:11 PM, a total of 12 shifts.</p>	F 309	<p>(MARs). Any medications not signed out during the previous 24 hours will be documented on the Unsigned Medication form. (see attached N-9) The supervisor will be notified and will then implement the Medication Errors policy. The resident will be assessed for any adverse effects. The supervisor will investigate the circumstances surrounding the missing initials and determine why the medication was not signed out as administered. The error will be documented on a Medication Error Report (see attached N-10) with corrective action noted on the form. The findings of the investigation will be reported to the Director of Nursing or designee.</p> <p>Example #2- R112 All residents individual bowel pattern will be now be reviewed daily by the Supervisory nurse and documented on the 3-day bowel tracker (see attached N- 12) Residents requiring bowel protocol will be listed on the 24 Hour Report. (see attached N-14)</p>		

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F 309	Continued From page 14 The November 2014 MAR was blank for bowel protocol medications, which indicated that R112 failed to receive the BM protocol medications when she had no BMs for 9 shifts as ordered.  Review of the Nurse's Notes from 11/20/14 through 11/24/14 lacked evidence that R112 had the bowel protocol initiated when the resident had no BMs in 9 shifts.  The facility failed to initiate the bowel protocol as ordered by E11 (physician). Findings were reviewed and confirmed with E5 (UM) on 12/10/14 at 3:28 PM.	F 309	C. Example #1 – R23. All nurses will be re-inserviced on the current Administrating Medications policy (see attached N-11 as well as revised Medication Error policy, which includes “medication not signed off as administered “ as a type of medication error.  Example #2- R112 All c.n.a.s will be re-trained on the proper documentation of bowel movements using the new electronic medical record system. All nursing staff will be inserviced on the new Bowel Movement protocol and monitoring procedure, which includes asking self-care residents about their bowel status (see attached N-13).		
F 323 SS=D	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 for one (R111) out of 33 Stage 2 sampled residents, the facility failed to ensure the resident environment remains free of accident hazards, specifically, a potential tripping hazard. Findings include:  An observation in R111's bedroom on 12/2/14 at 8:35 AM revealed a white cable across the floor and parallel to the window. The cable was a				

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F 309	Continued From page 14 The November 2014 MAR was blank for bowel protocol medications, which indicated that R112 failed to receive the BM protocol medications when she had no BMs for 9 shifts as ordered.  Review of the Nurse's Notes from 11/20/14 through 11/24/14 lacked evidence that R112 had the bowel protocol initiated when the resident had no BMs in 9 shifts.  The facility failed to initiate the bowel protocol as ordered by E11 (physician). Findings were reviewed and confirmed with E5 (UM) on 12/10/14 at 3:28 PM.	F 309	D. The DON or designee will monitor:  Example #1- R23 The Unsigned Medication form and Medication Error Reports will be reviewed daily until 100% accuracy related to proper documentation is achieved x 4 consecutive weeks. Then, they will be reviewed for one week each month for accuracy until 100% accuracy is achieved x 4 consecutive reviews. Then they will be reviewed once quarterly for accuracy maintaining 100% accuracy. Example #2- R 112 The 3-Day Bowel Tracker will be reviewed daily until 100% accuracy is achieved x 4 consecutive weeks. THEN, it will be reviewed for one week each month for accuracy until 100% accuracy is achieved x 4 consecutive reviews. Then it will be reviewed once quarterly for accuracy maintaining 100% accuracy.	1/26/15	
F 323 SS=D	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 for one (R111) out of 33 Stage 2 sampled residents, the facility failed to ensure the resident environment remains free of accident hazards, specifically, a potential tripping hazard. Findings include:  An observation in R111's bedroom on 12/2/14 at 8:35 AM revealed a white cable across the floor and parallel to the window. The cable was a				

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F 323	Continued From page 15 potential tripping hazard.	F 323	A. The cable cord in the room of R <sub>111</sub> which was installed by an outside vendor, was secured to the wall and off the floor by the maintenance staff		
F 333 SS=E	Findings were confirmed during an environmental tour with E7 (DCW) on 12/3/14 at 10:17 AM. 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 and interview, it was determined that the facility failed to ensure that residents were free of any significant medication errors for one (R47) out of 33 Stage 2 sampled residents. For R47, the facility failed, on multiple occasions, to separate the medication administration of Calcium/Caltrate with Vitamin D (Caltrate is a calcium supplement/antacid with Vitamin D to aid in absorption of the calcium) and Ferrous Sulfate (an iron supplement) by at least 2 hours from 10/16/14 through 12/10/14 for the morning doses. Findings include:  The facility's "Administering Medications" policy, last revised in 2/12, stated, "...The nurse administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified (i.e. [for example] - review of drug label, physician's order, et. [and others] ) before the medication is administered...".  The facility's "Medication Administration Errors Policy, 6.1" stated, "... A medication administration error occurs when a resident		B. All other resident rooms were checked for safety regarding cable, or other cords  C. 1. An Internal Facility Rounds form (see attached M-2) is in use by the Maintenance Director on random weekly tours in the residential areas  2. The RESIDENT ROOM DISCHARGE CLEANING AND MAINTENANCE PROTOCOLS Policy (see attached M-1) has been revised for use by maintenance and housekeeping staff to include the usage of the Internal Rounds Report to ensure the rooms are checked for any deficiencies. All staff have been inserviced on the new protocol  3. Monthly Safety Tours will also use the Internal Facility Rounds form (see attached M-2) on all inspections		

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F 323	Continued From page 15 potential tripping hazard.	F 323		
F 333 SS=E	Findings were confirmed during an environmental tour with E7 (DCW) on 12/3/14 at 10:17 AM. 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 and interview, it was determined that the facility failed to ensure that residents were free of any significant medication errors for one (R47) out of 33 Stage 2 sampled residents. For R47, the facility failed, on multiple occasions, to separate the medication administration of Calcium/Caltrate with Vitamin D (Caltrate is a calcium supplement/antacid with Vitamin D to aid in absorption of the calcium) and Ferrous Sulfate (an iron supplement) by at least 2 hours from 10/16/14 through 12/10/14 for the morning doses. Findings include:  The facility's "Administering Medications" policy, last revised in 2/12, stated, "...The nurse administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified (i.e. [for example] - review of drug label, physician's order, et. [and others] ) before the medication is administered...".  The facility's "Medication Administration Errors Policy, 6.1" stated, "... A medication administration error occurs when a resident	4. A Vendor sign-in sheet (see attached M-3) has been created to monitor the work of outside vendors by the maintenance staff. 5. In addition, the Nursing supervisor will monitor for compliance and document of the Shift Supervisor report form (see attached N-21)  D. The Maintenance Director reviews any completed reports, work orders and any work by an outside vendor daily basis. Any work orders received relating to unsecured cables in a residents room will be reviewed at weekly management meetings for 8 weeks for 100% compliance, then monthly for 4 months, then quarterly for 2 quarters and reported at monthly QAPI meetings.	1/9/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>086043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/15/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILTON &amp; HATTIE KUTZ HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>704 RIVER ROAD WILMINGTON, DE 19809</b>		
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F 333	<p>Continued From page 16</p> <p>receives a dose of medication that deviates from the original physician's order and/or established facility policy and procedure. Types of errors include: ... incorrect time of administration...".</p> <p>The facility's "Physician's Orders" policy, last revised in 2/12, stated, "... Physician orders are to be reviewed (recap/recapitulation) and rewritten every 30 days...".</p> <p>The facility's "Nursing 2015 Drug Handbook" on the units stated, "Ferrous Sulfate... Between-meal doses are preferable... Interactions: Drug - (to) Drug - antacids... may decrease Iron absorption. Separate doses...".</p> <p>On 10/3/14, R47 was hospitalized due to a fall with a broken left hip which was surgically repaired. R47 also had a diagnosis of osteoporosis (weakened bones with increased risk of breaking).</p> <p>On 10/7/14, R47 returned to the facility and R47's doctor ordered Ferrous Sulfate twice a day for anemia (a lack of enough healthy red blood cells [RBCs] to carry adequate oxygen to your tissues which may make you feel tired and weak) and Calcium with Vitamin D three times a day for osteoporosis.</p> <p>Review of the 10/14 MAR revealed that beginning 10/8/14 R47's Calcium was administered at 9 AM, 1 PM and 5 PM while Ferrous Sulfate was administered at 8 AM and 4 PM. There were 48 doses of these medications administered with only a one hour interval between them.</p> <p>On 10/10/14, R47 had blood work drawn which revealed that her RBCs were low at 3.05 per L</p>	F 333	<p>A. The medications (iron and calcium) for R47 were rescheduled to be given at least two hours apart on December 10, 2014. (see attached N-15)</p> <p>B. The consulting pharmacist will submit a status report for all previous recommendations not acted upon when conducting the monthly record review. (see attached example N-16)</p> <p>C. The Consulting Pharmacist will now include recommendations that have not been acted upon in his monthly medication review report. This will be reviewed by the Director of Nursing, the Executive Director and the Attending Physician. The Pharmacy Services Policy has been amended to reflect this procedure (see attached N-17). The nurses will be in serviced on the revised Pharmaceutical Services policy</p>		

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

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F 333	<p>Continued From page 17</p> <p>[lter] X [times] 100,000 units (normal range is 3.90 - 6.10) and her doctor ordered to repeat the blood work in one week.</p> <p>Upon the resident's readmission to the facility, the facility's Consultant Pharmacist completed an "Admission Review" of R47's medications, dated 10/12/14, which included, "...Dosing recommendations...Ferrous Sulfate and Calcium be dosed at least 2 hours apart from each other (Nursing) [This indicated that nursing was to change the dosing times to at least a 2 hour interval between the administration of calcium and iron]...".</p> <p>Record review revealed that on 10/16/14, E5 (UM) wrote "Done" next to the dosing recommendation on the "Admission Review" sheet for the administration of calcium and iron. However, review of the 10/14 MAR from 10/17/14 through 10/31/14 revealed the MAR continued to have the same administration times for the calcium and iron supplements with only a one hour interval rather than at least 2 hours between the administration of these medications.</p> <p>On 10/17/14, R47 had blood work drawn which revealed that her RBCs were low at 2.91 with no new orders given.</p> <p>On 10/29/14, the facility's recapitulation of R47's POS for 11/14 was done and failed to identify that calcium and iron supplements were both timed at 8 AM and 4 PM on the POS.</p> <p>On the 11/14 POS, R47's doctor continued the same orders for Calcium with Vitamin D three times a day and Ferrous Sulfate twice a day.</p>	F 333	<p>D. The DON or designee will monitor: The Consulting Pharmacist status reports monthly continuously for 100% compliance on an ongoing basis. Status Report review findings will be presented at the monthly QAPI meetings.</p>	1/26/15	

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

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F 333	<p>Continued From page 18</p> <p>Review of the 11/14 MAR revealed that R47's Calcium tablet was administered at 8 AM, 12 PM and 4 PM while Ferrous Sulfate was administered at 8 AM and 4 PM. There were 60 doses of these medications incorrectly administered at the same time for this month.</p> <p>On 11/27/14, the facility's recapitulation of R47's POS for 12/14 was done and failed to identify that calcium and iron supplements were both timed at 8 AM and 4 PM on the POS.</p> <p>On the 12/14 POS, R47's doctor continued the same orders for Calcium with Vitamin D three times a day and Ferrous Sulfate twice a day.</p> <p>Review of the 12/14 MAR revealed that R47's Calcium tablet was administered at 8 AM, 12 PM and 4 PM while Ferrous Sulfate was administered at 8 AM and 4 PM. There were 20 doses of these medications incorrectly administered at the same time for this month.</p> <p>In an interview on 12/10/14 at 9:23 AM, E5 (UM) confirmed that Calcium with D and Ferrous Sulfate were not administered with at least a 2 hour interval between them and that she would make the correction.</p> <p>On 12/10/14, R47's doctor was called and ordered additional blood work. On 12/11/14, the blood work results for iron were within normal limits and the RBCs were improved but still low at 3.55.</p> <p>The facility failed to ensure that R47's medication regime was free of significant medication errors due to the administered calcium and iron without a 2 hour interval between them for more than two</p>	F 333			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 19 months.				
F 371 SS=F	Findings were discussed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:15 PM. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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 observations and interviews, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include:  The facility policy #FO13 entitled, "Required Cleaning and Sanitization" stated, "...food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil ... Nonfood contact surfaces of equipment ... shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris ...".  1. On 12/1/14 at 8:30 AM, observation of the 8.5 and 14.5 inch diameter frying pans on the wall		<b>F 371</b> <b>Example #1</b>  A. No resident or individual was affected.  B. The pans were placed out of service. The remaining pots and pans were inspected and found to be compliant  C. Managers closing check list revised to include inspection of pots, pans and cooking utensils. New check list will be reviewed with team. (See attached D-1).  D. Sanitation supervisor to perform weekly audits of food contact surfaces to ensure compliance. Director of Dining Services and management staff to review closing check list daily. Findings to be reported for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters. Results will be documented during weekly management team meeting and results reported at monthly QAPI meeting for 12 months. 100% Compliance.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 20</p> <p>rack revealed that the food-contact and nonfood surfaces were encrusted with food debris. During the observation findings were immediately confirmed by E8 (DDS).</p> <p>The facility's policy #E004 entitled, "Uniform Dress Code" stated, "... Long facial hair must be covered with a surgical mask and/or hood ...".</p> <p>2. On 12/1/14 at 11:17 AM, E25 (Cook) was observed preparing six (6) sandwiches without wearing a facial hair restraint. Finding was immediately reviewed with E8.</p> <p>The facility's policy #F006 entitled, "Employee Guidelines: Infection Control Practices" stated, "...Use a spatula or tongs, or wear disposable gloves when handling food. Do not perform multiple activities while wearing gloves which will be used in food handling ... Handle glasses and cups by the bottom, without touching the rim ...".</p> <p>3. During the plating of food at the food line, the following unsanitary handling of food observations were made:</p> <ul style="list-style-type: none"> <li>- On 12/1/14 at 11:40 AM, E25 was observed touching serving utensils to plate food, used tongs for spaghetti, a ladle for spaghetti sauce then handled garlic bread with his soiled gloved left hand.</li> <li>- On 12/2/14 at 11:30 AM, E25 separated a stack of six, 12 fluid ounce Styrofoam cups by placing the thumb of his soiled left gloved hand in contact with the food surface.</li> <li>- On 12/2/14 at 11:43 AM, E25 was observed touching serving utensils to plate food and then proceeded to balance sliced quiche on a spatula with his soiled left gloved hand.</li> </ul>	F 371	<p>Example #2</p> <p>A. No resident or individual was affected.</p> <p>B. Staff member was personally instructed to follow proper hair restraint protocols.</p> <p>C. All staff to be re-in serviced on - Uniform Dress Code policy which includes hair restraint protocols. New pre service checklist implemented to include proper hair restraint usage. (see attached D-2)</p> <p>D. Director of Dining Services and management team to conduct daily observations of staff. Findings to be reported for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters. Results will be documented during weekly management team meeting and results reported at monthly QAPI meeting for 12 months. 100% Compliance.</p>		

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F 371	Continued From page 21 The facility's policy #C212 entitled, "Meal Temperature Record" stated, "...An accurate temperature of all menu items is to be taken and recorded, utilizing a calibrated thermometer. Refer to the standard temperatures as listed on the temperature log ...".  4. On 12/1/14 at 12:50 PM, a review of the kitchen Temperature Log and Checklist for November 2014 revealed that the temperature logs for 11/10, 11/13, 11/14, 11/17 and 11/22 through 11/28/14 were missing. Additionally, the temperature log for the dinner menu items for 11/19, 11/20, 11/21 and 11/30/14 were blank.  Findings were discussed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:15 PM.	F 371	<b>Example #3</b>  A. No resident or individual was affected.  B. E25 will be individually re-inserviced All staff to be re-in serviced on Employee Guidelines: Infection Control Practices. (see attached D-3) Director of Dining Services and management team will conduct on the job training to demonstrate proper food handling techniques.  C. Associate Guidelines: Infection Control Practices policy revised to now include: "While serving food during tray line use spoons, spatulas or tongs to handle food. Do not use hands to directly handle food."  D. Three meal periods per week for 4 weeks to be observed by DDS/management team at different times to ensure compliance. Findings to be reported for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters. Results will be documented during weekly management team meeting and results reported at monthly QAPI meeting for 12 months. 100% Compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the pharmacist report any irregularities to the			

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F 371	Continued From page 21 The facility's policy #C212 entitled, "Meal Temperature Record" stated, "...An accurate temperature of all menu items is to be taken and recorded, utilizing a calibrated thermometer. Refer to the standard temperatures as listed on the temperature log ...".  4. On 12/1/14 at 12:50 PM, a review of the kitchen Temperature Log and Checklist for November 2014 revealed that the temperature logs for 11/10, 11/13, 11/14, 11/17 and 11/22 through 11/28/14 were missing. Additionally, the temperature log for the dinner menu items for 11/19, 11/20, 11/21 and 11/30/14 were blank.  Findings were discussed with E1 (NHA) and E2 (DON) on 12/15/14 at approximately 4:15 PM. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the pharmacist report any irregularities to the	F 371	Example #4  A. No resident or individual was affected.  B. Culinary staff instructed to record daily tray line temperatures for all meal periods.  C. Culinary staff to be re-in serviced on Meal Temperature Record policy. Director of Dining Services/management team will instruct culinary team on proper temperature taking and recording procedures. New checklist implemented to ensure temperatures are being properly recorded. (see attached D-2)  D. Daily monitoring via use of tray line temperature logs by DDS/management team. Findings to be reported for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters. Results will be documented during weekly management team meeting and results reported at monthly QAPI meeting for 12 months. 100% Compliance.	1/19/15	
F 428 SS=D					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	<p>Continued From page 22</p> <p>attending physician and the DON and failed to have these reports acted upon for one (R47) out of 33 Stage 2 sampled residents. Findings include:</p> <p>The facility's "Pharmaceutical Services" policy, last revised in 6/13, stated, "...The focus of the consultant pharmacist includes preventing, identifying, reporting and resolving medication related problems and irregularities or potential for medication administration errors. He/she also reviews clinical as well as other records to determine that medications are administered as ordered and correct procedures are followed by licensed nursing staff..."</p> <p>On 10/3/14, R47 was hospitalized due to a fall with a broken left hip which was surgically repaired. R47 also had a diagnosis of osteoporosis (weakened bones with increased risk of breaking).</p> <p>On 10/7/14, R47 returned to the facility and R47's doctor ordered Ferrous Sulfate twice a day for anemia (a lack of enough healthy red blood cells [RBCs] to carry adequate oxygen to your tissues which may make you feel tired and weak) and Calcium with Vitamin D three times a day for osteoporosis.</p> <p>Review of the 10/14 MAR revealed that beginning 10/8/14 R47's Calcium tablet was administered at 9 AM, 1 PM and 5 PM while Ferrous Sulfate was administered at 8 AM and 4 PM.</p> <p>Upon the resident's readmission to the facility, the facility's Consultant Pharmacist completed an "Admission Review" of R47's medications, dated 10/12/14, which included, "...Dosing</p>	F 428	<p>A. The medications (iron and calcium) for R47 were rescheduled to be given at least two hours apart on December 10, 2014. (see attached N-15)</p> <p>B. The consulting pharmacist will submit a status report for all previous recommendations not acted upon when conducting the monthly record review. (see attached example N-16).</p> <p>C. The Consulting Pharmacist will now include recommendations that have not been acted upon in his monthly medication review report. This will be reviewed by the Director of Nursing, the Executive Director and the Attending Physician. The Pharmacy Services Policy has been amended to reflect this procedure (see attached N-17). The nurses will be in serviced on the revised Pharmaceutical Services policy.</p> <p>D. The DON or designee will monitor: The Consulting Pharmacist status reports monthly continuously for 100% compliance on an ongoing basis. Status Report review findings will be presented at the monthly QAPI meetings.</p>	1/26/15	

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F 428	<p>Continued From page 23</p> <p>recommendations...Ferrous Sulfate and Calcium be dosed at least 2 hours apart from each other (Nursing) [This indicated that nursing was to change the dosing times to at least a 2 hour interval between the administration of calcium and iron]...".</p> <p>Review of the 10/14 MAR from 10/17/14 through 10/31/14 revealed the MAR continued to have the same administration times for the calcium and iron supplements with only a one hour interval rather than at least 2 hours between the administration of these medications.</p> <p>On 10/24/14, the facility's consultant pharmacist conducted the monthly MRR but failed to identify and report that the dosing recommendations made on 10/12/14 for R47 had not been implemented for Calcium and Ferrous Sulfate.</p> <p>On the 11/14 POS, R47's doctor continued the same orders for Calcium with Vitamin D three times a day and Ferrous Sulfate twice a day.</p> <p>However review of the 11/14 MAR revealed that R47's Calcium and Ferrous Sulfate supplements were both incorrectly administered at the same time of 8 AM and 4 PM for the month.</p> <p>On 11/28/14, the facility's consultant pharmacist conducted the monthly MRR but failed to identify and report that the dosing recommendations made on 10/12/14 for R47 had not been implemented for Calcium and Ferrous Sulfate.</p> <p>The facility failed to ensure nursing acts upon the dosing recommendations identified on 10/12/14 by the consultant pharmacist for Calcium and Ferrous Sulfate to be administered at least 2</p>	F 428			

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F 428	Continued From page 24 hours apart from each other. Additionally, the facility's consultant pharmacist failed to identify and report on the 10/24/14 and 11/28/14 MRRs that the dosing recommendations identified on 10/12/14 were not implemented for R47. On 12/10/2014 at 9:23 AM, findings were confirmed by E5 (UM).	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,		<b>F431</b>  A. Unable to correct prior practice. No adverse effect to any resident.  B. Controlled Drug and Syringe count sheet modified to allow the shift supervisor to initial it, signifying that the on-coming and off-going nurses have signed the inventory sheet, attesting to the accuracy and completion of the controlled substance count. (see attached N-18)  C. Medications-Counting with off-going/on-coming shift policy was revised (see attached N- 19) to now include review by the shift supervisor, and additional documentation on the Shift Supervisor Report Form (see attached N-21) Nurses inserviced on the new policy (see attached N-20);	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/15/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILTON &amp; HATTIE KUTZ HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>704 RIVER ROAD WILMINGTON, DE 19809</b>	
(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 431	Continued From page 25 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on review of facility records and interviews, it was determined that the facility failed to ensure that a system for the reconciliation of controlled medications (medications whose use and distribution is tightly controlled by regulations) was performed by two licensed nurses at each shift change in 6 out of 6 hallways. Findings include:  The facility policy entitled, "Medications-Counting with OFF Going/Oncoming Shift", last reviewed on 3/15/13, stated, "... controlled drugs are to be counted by two licensed personnel per federal and state guidelines... At the nursing shift change: The on-coming nurse will count the number/volume of each controlled medication and inform the off going nurse of the count. The off going nurse will then compare the reported number/volume with the ... corresponding 'Controlled Count' sheet and verbally verify the count with the on-coming nurse. The 'Controlled Count' sheet is only to be signed after the count is verified as correct...".  Review of the facility's narcotic count forms on 12/4/14 at 9:15 AM revealed the following:	F 431	D... The DON or designee will monitor: The shift Supervisor Reports daily until 100% compliance for 4 consecutive weeks, THEN, For one week per month for 100% compliance for 3 consecutive months, THEN, Once a month for 100% compliance for 3 consecutive months. Review results will be reported at the monthly QAPI meeting.	12/10/14

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

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F 431	Continued From page 26 a. Review of the 100 Cart (100 Hallway) from 10/1/14 through 12/3/14 revealed that for 68 out of 192 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Controlled Drug and Syringe Count" form. In addition, there were twelve (12) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the form.  b. Review of the 200 Cart (200 and half of 300 Hallways) from 10/1/14 through 12/3/14 revealed that for 39 out of 192 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Controlled Drug and Syringe Count" form. In addition, there was one (1) missing shift inventory count where both the nurse going off duty and the nurse coming on duty failed to sign the form.  c. Review of the 400 Cart (400 and other half of 300 Hallways) from 10/1/14 through 12/3/14 revealed that for 13 out of 192 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Controlled Drug and Syringe Count" form. In addition, there was one (1) missing shift inventory count where both the nurse going off duty and the nurse coming on duty failed to sign the form.  d. Review of the 500 Cart (500 Hallway) from 10/1/14 through 12/3/14 revealed that for 33 out of 192 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Controlled Drug and Syringe Count" form. In addition, there were two (2) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the form.	F 431			

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NAME OF PROVIDER OR SUPPLIER  <b>MILTON &amp; HATTIE KUTZ HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>704 RIVER ROAD WILMINGTON, DE 19809</b>		
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F 431	Continued From page 27 e. Review of the 600 Cart (600 Hallway) from 10/1/14 through 12/3/14 revealed that for 27 out of 192 shifts; either the nurse going off duty or the nurse coming on duty failed to sign the "Controlled Drug and Syringe Count" form. In addition, there were two (2) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the form.  The facility failed to ensure that narcotic inventory counts were reconciled by two nurses during shift changes multiple times from 10/1/14 through 12/3/14.  Findings were confirmed with E6 (RN UM) on 12/4/14 at 10:05 AM.				
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN  The facility must provide or obtain laboratory services only when ordered by the attending physician.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that laboratory services were provided only when ordered by the attending physician for one (R47) out of 33 Stage 2 sampled residents. Findings include:  R47 had a diagnosis of hypothyroidism (under active thyroid gland that includes symptoms such as fatigue, weight gain, muscle weakness, muscle aches, slowed heart rate, memory		<b>F 504</b>  IDR requested  A. R47 had a TSH drawn on 10/3/14. She was hospitalized later that day. She returned to the facility on 10/7/14. Readmission orders, dated 10/7/14 included an order for 'TSH q 6 months April/October'. She had a current physician's order when the TSH was drawn on 10/8/14. (see attached N-22).  B. When a resident with standing orders is hospitalized, the lab will be notified by fax to discontinue the current standing orders. "Resident in the hospital" will be written on the resident's "Monthly Advanced Draw Listing" form and faxed to the lab. (see attached N-24). This will be noted on the 24 Hour Nursing Report. (see attached N-14)		

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F 504	Continued From page 28 problems and depression).  On the 10/14 POS, R47's doctor ordered bloodwork, a TSH (Thyroid Stimulating Hormone) (a blood test used to detect problems affecting the thyroid gland) every 6 months (April/October).  Record review revealed that R47 had a TSH done on 10/3/14 that was within normal limits. However, on 10/8/14, without a doctor's order, another TSH blood test was incorrectly drawn.  In an interview, on 12/10/14 at 9:23 AM, E5 (UM) confirmed the findings  The facility failed to ensure that R47 had blood work drawn only when ordered by her doctor when a second TSH was incorrectly drawn without any order on 10/8/14.	F 504	C. Laboratory Studies policy was written to address "standing orders" involving lab work. (see attached N-23) .The nurses will be in- serviced on the new "Standing Orders" lab policy.  D. The Director of Nursing or designee will: Review the 24 Hour Report daily to verify lab notification to discontinue standing orders daily for 100% compliance for 4 consecutive weeks. Then, for one week per month for 100% compliance for 3 months then once a month for 3 months for 100% compliance.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced	F 514	IDR requested  A. The identified forms were part of a closed record from a previous admission, not thinned from the current medical record. The forms were not placed in the current record as they are not relevant to this admission.	1/26/15	

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F 514	Continued From page 29 by: Based on observation and record review, it was determined that the facility failed to maintain clinical records on each resident that has sufficient information of the resident's assessment and that is readily accessible for one (R34) out 33 Stage 2 sampled residents. Findings include:  Review of the Admission Evaluation and Interim Care Plan dated 1/12/12 had stamped on the front, "Please Do Not Remove From Chart," surveyor found it in R34's thinned record and not part of the active chart.  Review of the Physician Admission/Monthly Orders dated 1/12/12 had stamped on the front, "Please Do Not Remove From Chart," surveyor found it in R34's thinned record and not part of the active chart.  Findings were discussed with E1 (NHA) and E2 DON on 12/15/14 at approximately 4:20 PM.	F 514	B. As per the Home's practice, and explained to nurses during a staff meeting on June 19, 2014, "a new medical record is initiated if a resident has been hospitalized for 7 days or longer". (see attachments N-25, 26 and N-27) . The Medical Records policy has been revised to be more specific regarding thinning charts as well as when a resident's chart is to be closed and a new one opened. (see attached N-28) .  C. The medical record clerk will be inserviced on this policy.  D. The Director of Nursing of designee will: Review 20% of all thinned charts for forms incorrectly removed monthly for 100% compliance X six months The record review results will be reviewed at the monthly QAPI meeting.	1/26/15	



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

**STATE SURVEY REPORT**

**NAME OF FACILITY: Milton & Hattie Kutz Home**

**DATE SURVEY COMPLETED: December 15, 2014**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.1.0	<p>An unannounced annual survey was conducted at this facility from December 1, 2014 through December 15, 2014. 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 83. The Stage 2 survey sample size was 33.</p>	
3201.1.2	<p><b>Skilled and Intermediate Care Nursing Facilities</b></p>	
	<p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p>	
3201.7.0	<p>Cross refer to the CMS 2567-L survey exit date 12/15/14, F170, F241, F246, F253, F272, F278, F309, F323, F333, F371, F371 example 4, F428, F431, F504 and F514.</p> <p><b>Plant, Equipment and Physical Environment</b></p>	<p>Cross refer to the CMS 2567-L survey exit date 12/15/14, F170, F241, F246, F253, F272, F278, F309, F323, F333, F371, F371 example 4, F428, F431, F504 and F514.</p> <p>Completion date: 1/26/15</p>



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<p><b>3201.7.5</b></p>	<p><b>Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on dietary observations during the survey, it was determined that the facility failed to comply with sections 2-402.11 (A), 3-301.11 (B), 3-304.15 (A), 4.601.11 (B), 4-601.11 (C) and 4-904.11 (A).</p> <p><b>2-402.11 Effectiveness.</b></p> <p><b>(A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE_SERVICE and SINGLE_USE ARTICLES.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 2.</p> <p><b>3-301.11 Preventing Contamination from Hands.</b></p> <p><b>(B) Except when washing fruits and vegetables as specified under § 3- 302.15 or as specified in ¶ (D) of this section, food employees may not contact exposed, ready-to-eat food with</b></p>	<p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 2.</p> <p>Completion date: 1/19/15</p>
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Provider's Signature

Title

EXECUTIVE DIRECTOR

Date

1-8-15



NAME OF FACILITY: Milton & Hattle Kutz Home

DATE SURVEY COMPLETED: December 15, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p><b>3-304.15 Gloves, Use Limitation.</b></p> <p><b>(A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p><b>4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils.</b></p> <p><b>(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be free of encrusted grease deposits and other soil accumulations.</b></p> <p><b>(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</b></p> <p><b>This requirement is not met as evidenced by:</b></p>	<p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p>Completion date: 1/19/15</p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p>Completion date: 1/19/15</p>



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<p>16 Del. C., Chapter 11, § 1162.</p>	<p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 1.</p> <p><b>4-904.11 Kitchenware and Tableware.</b></p> <p><b>(A) Single-Service and single-use articles and cleaned and sanitized utensils shall be handles, displayed, and dispensed so that contamination of food- and lip-contact surfaces is prevented.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p><b>Nursing staffing.</b></p> <p><b>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be</b></p>	<p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 1.</p> <p>Completion date: 1/19/15</p> <p>Cross refer to the CMS 2567-L survey completed 12/15/14, F371, example 3.</p> <p>Completion date: 1/19/15</p> <p>A. Unable to correct past practice. No residents effected.</p> <p>B. The administrator of the staffing agency was contacted by phone and in writing regarding the requirement for photo IDs for his employees. He acknowledged in writing his understanding of the requirement and that his staff has been in serviced. (see attachments N-29and 30). The nursing supervisor will observe all agency staff at the beginning of the shift for proper identification badges. Anyone not wearing an approved badge will be sent home to get the badge and the agency will be contacted.</p> <p>C. The Employee Identification Badge policy</p>



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	<p><b>required to wear photo identification listing their names and titles.</b></p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that an agency caregiver was wearing a photo ID (Identification) badge.</p> <p>On 12/9/14 at 9:05 AM, E13 (Certified Nurse's Aide/CNA from an agency) was observed outside of R23's room, not wearing any type of ID badge. When asked where her ID badge was during an interview immediately following the observation, E13 stated that she worked through an agency and that her name badge was "not ready yet."</p> <p>On 12/11/14 at approximately 3 PM, findings were confirmed with E14 (RN, Weekend Supervisor). E14 telephoned the agency and reported that she was told that this CNA did have an identification badge and that the agency would speak with her when she reported back to the agency.</p>	<p>was updated to include agency staff requirements. (see attached N-31). The supervisor will note any violations of this policy on the Supervisor Shift report (see attached N-21)</p> <p>D. The Director of Nursing or designee will: Review the Shift Supervisor Report daily for 100% compliance for 4 consecutive weeks; THEN for one day per week for 95% compliance for 4 consecutive weeks; Then, once monthly for 95% compliance for 3 consecutive months. Findings will be reported at the monthly QAPI meeting.</p> <p>Completion date: 1/26/15</p>