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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085020		08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS	F 000		
	An unannounced annual survey was conducted at this facility from August 17, 2015 through August 25, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 141. The stage two survey sample was thirty-seven (37). Abbreviations/Definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; FMD-Facility Maintenance Director; NP - Nurse Practitioner; PA - Physician Assistant; ADLs - Activities of Daily Living, such as bathing and dressing; PRN - As needed; MAR - Medication Administration Record (on paper); eMAR - Electronic Medication Administration Record (in the computer); MDS - Minimum Data Set (standardized assessment used in nursing homes); BM - Bowel movement;		The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements	11/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
10/14/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000	F 225	
	BP (Blood Pressure) - measure of the force of the blood against the walls of a blood vessel; BPH (Benign Prostatic Hypertrophy) - enlarged prostate; Fr (French) - measurement of diameter; mL (milliliter) - metric measurement of liquid volume, 5mL equals 1 teaspoon; MOM - Milk of Magnesia, medication to promote a bowel movement; QA - Quality Assurance; QI- Quality Improvement; Antipsychotic - medication used to treat psychosis-a loss of control with reality-and other mental conditions; Cognition - mental abilities, thinking; Continent - control of bladder and/or bowel function;. Delusion - false belief that is thought to be true; Diabetes - disease where blood sugar levels are too high; Dulcolax - medication to promote a bowel movement; Senna-medication used to treat constipation; Enema - Fluid inserted in the rectum to promote a bowel movement; Foley/indwelling catheter - tube held in the bladder by a small balloon to drain urine; Hallucination - something that seems real but does not really exist; Hemiplegia or hemiparesis - half of the body is paralyzed (left or right side); Incontinent - loss of control of bladder and/or bowel function; Insulin - medication injected under the skin to control blood sugar levels; Pulse - the beat of the heart felt through the walls of an artery; Retention - abnormal retaining of fluid in a body cavity.		A. 1. Report submitted on 8/21/2015involving R156 and R159 B. All residents have the potential to be affected by this practice. All Allegations of abuse, neglect and mistreatment since the end of the survey have been reviewed and any required action was followed. C. All Supervisory Staff to be in serviced by Staff Development proper guidelines for reporting all allegations of abuse, neglect and mistreatment to appropriate management. ATTACHMENT A D. Weekly audit of reports Allegations of abuse, neglect and mistreatment of to ensure investigations are complete, a root cause identified, if possible, and reporting requirements are met if applicable. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT B	11/3/15

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F 225 A. 2. Report for incident involving R156 submitted on 5/28/2015. B. All residents have the potential to be affected by this practice. All Allegations of abuse, neglect and mistreatment since the end of the survey have been reviewed and any required action was followed. C. All Supervisory Staff to be in serviced by Staff Development proper guidelines for reporting all allegations of abuse, neglect and mistreatment to appropriate management. ATTACHMENT A D. Weekly audit of reports Allegations of abuse, neglect and mistreatment of to ensure investigations are complete, a root cause identified, if possible, and reporting requirements are met if applicable. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT B	11/3/15

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F 225	Continued From page 3	F 225		
	This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that for three (R156, R182 and R159) out of 37 sampled residents the facility failed to ensure incidents of resident to resident abuse were immediately reported to the State agency. Findings include: 1. Review of facility documentation from a resident to resident abuse incident on 8/15/15 involving R156 hitting and scratching R159 revealed that although an investigation was conducted the facility failed to immediately report the incident to the State agency. 2. Review of facility documentation from a resident to resident abuse incident on 5/27/15 at 12:45 PM involving R156 hitting and scratching another resident, revealed that the facility failed to immediately report the incident to the State agency. The incident was not reported until 5/28/15 at 2:11 PM. 3. Review of a facility documentation from a resident to resident abuse incident on 5/27/15 at 12:45 PM involving R182 being hit and scratched by another resident, revealed that the facility failed to immediately report the incident to the State agency. The incident was not reported until 5/28/15 at 2:11 PM. An interview on 8/21/15 at 10:03 AM with E3, ADON revealed that the incident with R159 was not reported because when the wound nurse looked at R159 the next day she did not see an injury. There was no further information on why		F 225 A. 3. Report for incident involving R182 submitted on 5/28/2015. B. All residents have the potential to be affected by this practice. All Allegations of abuse, neglect and mistreatment since the end of the survey have been reviewed and any required action was followed. C. All Supervisory Staff to be in serviced by Staff Development proper guidelines for reporting all allegations of abuse, neglect and mistreatment to appropriate management. ATTACHMENT D. Weekly audit of reports Allegations of abuse, neglect and mistreatment of to ensure investigations are complete, a root cause identified, if possible, and reporting requirements are met if applicable. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT B	11/3/15

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F 225	Continued From page 4	F 225	F241	
F 241 SS=D	the resident to resident incident in which R182 was scratched was not immediately reported to the State agency. She further stated that the procedure would be to contact the DON or the ADON at the time of the incident to get direction on reporting. These findings were reviewed with E1, NHA and E2, DON on 8/25/15 at 2:30 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 observation it was determined that the facility failed to care for residents in a manner that maintained or enhanced each resident's dignity and respect for 3 (R85, R264 and R266) out of 37 sampled residents. Findings include On 8/17/15 between 11:55 AM - 11:57 AM in the Aspen unit's dining room during lunch the following were observed: 1. E9 (CNA) placed a clothing protector on R85, R264 and R266 without asking permission. None of these residents had an intervention in their care plan addressing use of the clothing protector. All residents were verbal and could state their wishes 2. R264 was seated in her wheelchair over a foot	F 241	A. 1. Residents R85, R264 and R266 to be offered clothing protectors. B. All residents have the potential to be affected by this practice. C. All staff to be educated by Staff Development on resident dignity. Attachment C D. Weekly audit of dining rooms to ensure resident dignity is maintained. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT D	11/3/15

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F 241	Continued From page 5	F 241	F241	
	away from the table and needed to extend her arm completely to reach the food on her plate. Foot rests from other residents wheelchairs at the table prevented R264 from being positioned closer to the table as she was the last to arrive. After approximately 15 minutes R264 was asked by facility staff if she wanted to move to another table to be closer to her plate and she agreed. The resident was able to finish her meal without needing to extend her arm fully to reach her food. The facility failed to provide care during a meal in a way that maintained dignity for three residents. These findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.		A. 2. R264 was moved to a different table to allow appropriate seating so resident doesn't have to stretch to feed herself. B. All residents have the potential to be affected by this practice. C. All staff to be educated by Staff Development on resident dignity. The frequency of training will be determined by the identified trends in the audits in Element D. Attachment C	11/3/15
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure for one (R92) out of 37 sampled residents that the twice a week shower schedule was carried out. Findings include: R92's Admission MDS dated 5/8/15 and Quarterly MDS dated 8/6/15 indicated the resident was	F 242	D. Weekly audit of dining rooms to ensure resident dignity is maintained. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT D	

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F 242	Continued From page 6 totally dependent on staff for bathing. The resident's care plan for ADLs dated 9/4/14 and reviewed quarterly documented the plan to assist with bath/shower as needed. The resident's plan of care in the CNA bath book was to have a tub/shower on Tuesdays and Fridays on the 3 PM to 11 PM shift. Review of the CNA documentation revealed that between 6/1/15 and 8/21/15 R92 only received 14 out of 24 scheduled baths. Interviews on 8/24/15 at 3:33 PM with E12, evening nursing supervisor and E13, evening LPN revealed that they were unaware of R92 missing baths or there being any problems that kept staff from bathing this resident. These findings were reviewed with E1, NHA and E2, DON on 8/25/15 at 2:30 PM.	F 242	F242 A. Since the competition of the survey, R92 has received scheduled tub/shower as indicated in the plan of care and any issues have been resolved. B. All residents have the potential to be affected by this practice. C. All direct care staff to be educated by Staff Development on resident plans of care for ADL and completion of care tracker prior to the end of each shift. Attachment E. D. Weekly audit of Missed Observation Report. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT F.	11/3/15
F 253 SS=B	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 that for 5 (110, 226, 309, 329, and 336) out of 36 rooms reviewed the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings include:	F 253		

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F 253	Continued From page 7	F 253		
	Observations noted in stage 1 from 8/17/15 through 8/19/15 (8:00 AM - 4:00 PM were verified by E8 (FMD) on 08/24/15 between 11:20 AM and 11:50 AM. The following were observed: - loose towel bars in the bathrooms of rooms 110 and 329 - wall, doorway, and/or baseboard damage in bathrooms of rooms 309, 329, and 336 - loose plumbing fixtures on a sink in room 226 All findings were reviewed and confirmed by E8 during the environmental tour on 08/25/15 from 9:30 AM to 9:40 AM. These findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.		F253 A. Loose towel bars in rooms 110 and 329 were repaired. Loose plumbing fixture in room 226 was repaired. The wall, doorway and baseboard damage in bathrooms in rooms 309, 329 and 336 were repaired. B. A facility wide audit will be conducted during daily ambassador rounds to ensure areas in need of repair are noted and reported through the REQQER (electronic record maintenance system) system. All issues will be recorded and repaired timely. C. Maintenance Director to in service IDT team on conducting daily ambassador rounds and entering items into the REQQER (electronic record maintenance system) system. The frequency of training will be determined by the identified trends in the audits in Element D. Attachment G. D. The Maintenance Director or designee will conduct weekly audits of REQQER requests to ensure timely completion of maintenance related issues weekly for four weeks then monthly times two months. The numbers of completed, as well as, open maintenance items are reported at monthly QAPI meeting. Attachment H	11/3/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 8	F 272		
	Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.		F272 A. Active Diagnosis for Resident 248 corrected in the MDS. B. All Residents have the potential to be affected by this practice. All active diagnoses are accurate in residents MDS. C. MDS staff educated by RNAC on proper procedure for assessing and coding each resident's active diagnoses. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT I	11/3/15
	This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately assess the active diagnosis of hemiplegia or hemiparesis for one (R248) out of 37 sampled residents. Findings include: On 5/27/15 the physician documented in a history and physical the resident had had a stroke with left hemiparesis. The diagnosis of left hemiplegia was also documented as a diagnosis on the hospital transfer sheet dated 6/25/15. The post-hospital Entry MDS dated 7/12/15 stated "no" for number 14900, hemiplegia or hemiparesis in Section I - Active Diagnoses. An interview with E10 (MDS Coordinator) on		D. Weekly audit of MDS records for accurate assessment and coding of residents active diagnoses. These audits will be done weekly for 4 weeks until 100% success is achieved. The results of these audits will be submitted to the QA committee. The QA committee will determine the need for further submissions. ATTACHMENT J.	

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F 272	Continued From page 9	F 272		
	8/24/15 at 1:30 PM confirmed that the diagnosis entry was inaccurate on the MDS and that the correct answer should have automatically flowed into that section. The facility failed to accurately assess and document the resident's active diagnosis of hemiplegia in the MDS. These findings were reviewed with E1(NHA) and E2 (DON) on 8/25/15 at 2:30 PM.		F279 A. Resident R1 Care plan was reviewed and revised to reflect accurate cognition. B. All residents have the potential to be affected by this practice. C. DON to educate UMs on reviewing Care Plans quarterly for accuracy. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT K. D. Audits will be completed weekly for each nursing unit to ensure that accurate and appropriate care plans are in place. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT L	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		11/3/15

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F 279	Continued From page 10	F 279		
	Based on record review and interview it was determined that the facility failed to review and revise the plan of care for 1 (R1) out of 37 sampled residents. Findings include: R1's care plan included a problem entitled episodes of anxiety related to terminal brain cancer (initiated 3/18/14 and reviewed quarterly throughout the stay at the facility). Review of this resident's record on 8/21/15 found no evidence of cancer. Interview with E6 (UM) on 8/25/15 at 9:47 AM confirmed the wording of the care plan problem. E6 stated she was not aware of a cancer diagnosis for this resident but would check with E4 (former UM). E6 removed the cancer reference from the care plan problem and changed it to reflect the resident's cognition. The facility failed to have an accurate care plan problem for one resident. These findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.			11/3/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 280	Continued From page 11	F 280	F280	
	interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R30) out of 37 sampled residents the facility failed to revise the care plan to reflect current care needs. Findings include: R30's care plan for urinary incontinence dated 2/13/15 documented the following approaches; - apply barrier cream - check for incontinence frequently and provide incontinent care as needed - provide assistance with toileting or provide incontinent care as needed (2/25/15) - remind and assist as needed with toileting at routine times such as upon rising in the morning, before/after meals, activities, therapy and bedtime. - toilet every two hours and as needed (2/19/15) - use absorbent products such as pads, liners, adult briefs to assist with moving urine away from skin/clothing and to preserve dignity. An interview on 8/21/15 at 3:02 PM with E6, RN Unit Manager revealed that R30 was admitted to		A. Resident R30 care plan revised to reflect current care needs. B. All residents have the potential to be affected by this practice. C. DON to educate UMs on reviewing Care Plans quarterly for accuracy. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT K. D. Audits will be completed weekly for each nursing unit to ensure that accurate and appropriate care plans are in place. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT L.	11/3/15

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F 280	Continued From page 12	F 280		
	her unit on 2/12/15. The resident since admission would not get up and use the toilet. Staff would attempt to use the bed pan but the resident was usually already incontinent. She stated that R30 had pretty much been a check and change every two hours since admission. E6 confirmed that the care plan approaches had not been updated to accurately reflect the care provided to R30. These findings were reviewed with E1, NHA and E2, DON on 8/25/15 at 2:30 PM.		F309	
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 review and interview it was determined that the facility failed to provide the necessary care and services according to the physician order for 2 (R1 and R46) out of 37 sampled residents. Both R1 and R46 did not have the bowel protocol initiated on several occasions. R46's blood pressure (BP) and pulse were not obtained weekly as ordered. Facility policy entitled Bowel Protocol Guidelines (undated) stated the 7-3 (day) shift would obtain a list of residents with no bowel movement for 3 days and write the name and medications given	F 309	A. 1. R1 has proper interventions in place for BMs since survey ended 8/25/2015. B. All residents have the potential to be affected by this practice. C. Staff Development to educate all RN and LPN staff on Bowel Protocol. Review Care Tracker Reports daily at clinical meeting to identify any residents needing BM protocol. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT M. D. Weekly Audits of Care Tracker. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT N.	11/3/15

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F 309	Continued From page 13 on the tracking sheet. Each shift would document on the tracking sheet until the resident had a BM. Day shift would administer MOM if the resident had not had a BM in 3 days. Evening shift would administer Dulcolax if no results from the MOM. Night shift would administer an enema if no results from the Dulcolax. Protocol given and results were to be documented in a nursing note. 1. R1's physician order for the bowel protocol was dated 7/28/13. Review of the 5/1/15 - 8/20/15 report entitled Resident Bowel and Bladder by Shift (CNA electronic documentation) found that the bowel protocol should have been initiated 4 times (May 10, June 30, July 8, July 20). The protocol was initiated only once on May 10. Review of the resident's MAR and nurses notes found no evidence that the bowel protocol medications were administered as ordered nor if R1 refused them for two of the dates (6/30/15 and 7/8/15). On 7/20/15 R1 was given Dulcolax on the evening shift even though the protocol was to start with MOM. There was no evidence in the nurses notes or MAR that MOM was given or if the resident refused the MOM on the day shift. 2a. R46 had a diagnosis of constipation and received a senna laxative twice a day since the medication and the bowel protocol was ordered on 9/2/14. Review of R46's 5/1/15 - 8/20/15 report entitled Resident Bowel and Bladder by Shift found that the bowel protocol should have been implemented 2 times (July 26 and August 15). Review of the MAR and nurses notes found	F 309	F309 A. 2a. R46 has proper interventions in place for BMs Since survey ended 8/25/2015. B. All residents have the potential to be affected by this practice. C. Staff Development to educate all RN and LPN staff on Bowel Protocol. Review Care Tracker Reports daily at clinical meeting to identify any residents needing BM protocol. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT M. D. Weekly Audits of Care Tracker. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT N.	

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F 309	Continued From page 14	F 309		
	no evidence that the bowel protocol medications were administered as ordered or that the resident refused them for either of these dates. The bowel protocol findings were confirmed with E7 (QI Nurse) on 8/25/15 at 1:10 PM as she was unable to locate documentation in the nurses notes or the MAR that the bowel protocol was initiated for these residents. The facility failed to consistently initiate the bowel protocol for two residents. The bowel protocol findings were reviewed with E1 (NHA) by telephone on 8/26/15 at 10:09 AM.		F309 A. 2b. R46 BP and pulse have been taken per physician orders and recorded in MAR. 8/25/2015 B. All residents have the potential to be affected by this practice. C. All LPN and RN Nursing Staff to be in serviced by Staff Development for MAR/TAR Documentation. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT O D. Weekly Audits of MAR/TAR documentation to be completed. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT P	11/3/15
	2b. R46's physician order dated 9/4/14 stated the resident was to have a BP and pulse obtained weekly on Monday day shift. The resident has a history of high blood pressure and was receiving medication for this condition. Review of R46's MAR from June and July, 2015 found the following missing entries: * 6/8/15: BP and pulse * 6/22/15: pulse * 6/29/15: BP * 7/6/15: BP and pulse The missing blood pressures and pulses were confirmed with E7 (QI Nurse) on 8/25/15 at 1:05 PM since she was unable to locate BP and pulse documentation in the nurses notes or the vital sign section of the electronic medical record for this resident. These findings were reviewed with E1 and E2 (DON) on 8/25/15 at 2:30 PM.			
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315	Continued From page 15	F 315		
SS=D	RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that for 1 (R131) out of 37 sampled residents, an indwelling catheter is not used unless there is valid medical justification and that the continued use of an indwelling catheter that is not medically justified, is discontinued as soon as clinically warranted. Findings include: R131 was re-admitted to the facility on 6/23/15 after hospitalization and had a diagnosis of BPH with retention. R131's initial care plan (dated 7/1/12 and last reviewed 7/29/15) included use of an indwelling urinary catheter due to BPH with obstruction. The use of the indwelling catheter was documented in the 5-day MDS (dated 6/30/15), the 14-day MDS (dated 7/5/15) and the 30-day MDS (dated 7/19/15). Physician order dated 7/28/15 stated: - Change indwelling catheter monthly		F315 A. Resident R131 has been seen by an urologist and has the appropriate diagnosis to continue the indwelling catheter B. All residents have the potential to be affected by this practice. Residents with indwelling catheters to be audited to ensure proper documentation are in place. C. All residents with indwelling catheters to be identified and reviewed weekly to ensure proper documentation is in place D. Weekly Audits of residents with indwelling catheters to ensure proper diagnosis is in place. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT Q	11/3/15

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F 315	Continued From page 16	F 315		
	- Change catheter drainage bag monthly & pm - Foley 16 Fr, balloon size 10 mL, diagnosis of BPH with retention - Maintain indwelling catheter tension relieving leg strap and dignity bag at all times, check for placement Physician order dated 8/14/15 placed the resident on comfort care. During an interview on 8/24/15 at 2:15 PM E4 (Wound Nurse) could not produce evidence that R131 had been seen by a urologist since returning to the facility on 6/23/15. E4 was unaware that when a resident had an indwelling catheter, medical justification was necessary. During an interview on 8/24/15 at 2:00 PM with E28 (CNA who was assigned to work with R131 that day) she stated that the resident required total assistance with ADLs including feeding and confirmed that the resident did have an indwelling catheter. The facility failed to produce documentation that R131 had been seen by a urologist or other physician since his 6/23/15 admission to determine the continued necessity of the indwelling catheter. These findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.			11/3/15
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	F 323		

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F 323	Continued From page 17	F 323	F323	
	adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for 2 (115 and 329) out of 36 rooms reviewed during stage 1 the facility failed to ensure that the resident environment remained as free of accident hazards as possible. Observations were made during stage 1 between 8/17/15 through 8/19/15 (8:00 AM - 4:00 PM) and again on 08/24/15 from 11:20 AM to 11:50 AM. Findings include the following observations: - loose grab bars in the bathrooms of rooms 115 and 329 Findings were reviewed on 8/25/15 with E8 (Facility Maintenance Director) at 10:35 AM and with E1 (NHA) and E2 (DON) at 2:30 PM.		A. Loose grab bars in Room 115 and 329 bathrooms were repaired B. A facility wide audit will be conducted during daily ambassador rounds to ensure areas in need of repair are noted and reported through the REQQER (electronic record maintenance system) system. All issues will be recorded and repaired timely. C. Maintenance Director to in service IDT team on conducting daily ambassador rounds and entering items into the REQQER (electronic record maintenance system) system. The frequency of training will be determined by the identified trends in the audits in Element D. Attachment G.	11/3/15
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368	D. The Maintenance Director or designee will conduct weekly audits of REQQER requests to ensure timely completion of maintenance related issues weekly for four weeks then monthly times two months. Attachment H.	

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F 368	Continued From page 18	F 368		
	When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that the facility failed to assure that there was no more than 14 hours between a substantial evening meal and breakfast for the Main Dining Room without approval of the resident group. Documentation of meal times provided by the facility revealed that the time lapse between the 5 PM evening meal and 8 AM breakfast for the main dining room was 15 hours. E14 (Diet Manager) stated during an interview on 8/20/15 between 11:40 AM-12:10 PM that meal times in the main dining room had been that way for over 10 years and the residents liked it that way. Substantial snacks, like sandwiches are provided on the evening shift. E6 (UM) stated during an interview on 8/20/15 at 3:09 PM that, besides bedtime snacks for diabetics, the kitchen sends a large tray of items (sandwiches, peanut butter crackers, cookies, fruit) to be used for residents on the evening and night shifts. On 8/21/15 at 9:23 AM E14 verified that substantial snacks get provided for evening and		F 368 A. Residents discussed and approved Main Dining Room hours that have a 15 hour span of time between dinner and breakfast with an offering of a substantial snack during the evening. B. Residents that eat in the main dining room have the potential to be affected by this deficient practice. C. Main Dining Room hours to be review monthly at resident council and get approval by the residents. Current Main Dining Room hours will remain the same. D. Resident council minutes to be audited monthly to ensure approval of resident council of Main Dining Room hours. The outcome of resident council meeting minutes will be reviewed at monthly QI (QAPI) meeting to determine if Main Dining Room Hours need to change. ATTACHMENT R	11/3/15

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F 368	Continued From page 19	F 368		
	nights shifts so all residents who want can have something. This was in addition to the snacks ordered by the dietitian. E14 had no knowledge or documentation that residents were in agreement with the 15 hours (with snack offerings) time span. The diet manager stated that a resident council meeting is upcoming and she could bring up the topic at the meeting in order to gain formal approval. On 8/24/15 minutes from the monthly resident council minutes covering January, 2015 through July, 2015 revealed no evidence of resident discussion of the time span from dinner to breakfast with a nourishing evening snack. During an interview on 8/25/15 at 9:58 AM R159 (Resident Council President) and E15 (Activities Director) confirmed there was no discussion at council meetings from the past year about the length of time between dinner and breakfast in the main dining room. The facility failed to assure there was no more than 14 hours between a substantial evening meal and breakfast for the Main Dining Room without approval of the resident group. These findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.			11/3/15
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		

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F 463	Continued From page 20	F 463		
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for 1 (114) out of 36 rooms reviewed during stage 1 the facility failed to ensure all portions of the call system were functioning. Findings include: Observations made during stage 1 between 8/17/15 through 8/19/15 (8:00 AM - 4:00 PM), on 08/24/15 at 11:28 AM and on 08/25/15 at 10:05 AM revealed the call bell cord in the bathroom of room 114 was wrapped tightly around the grab bar. This made it unable to activate if the cord was pulled below the level of the grab bar. The finding was reviewed and confirmed by E21 (LPN) on 08/25/15 at 10:05 AM, who unwrapped the call bell cord at that time. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/25/15 at 2:30 PM.		F463 A. Call bell is no longer wrapped around grab bar in 114 B. All residents have the potential to be affected by this practice. C. All Staff to be in serviced by Staff Development on call bell placement. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT S D. Random audits to be conducted for proper call bell placement. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the random audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT T.	11/2/15
F 514 SS=E	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;	F 514		

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F 514	Continued From page 21 and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain complete and accurate clinical records for 3 (R1, R46 and R131) out of 37 sampled residents. For R1 the facility did not consistently document resident behaviors and side effects for antipsychotic medications, nor did the facility accurately record the amount of evening snack consumed. For R46 the facility did not consistently document behavior monitoring and side effects for antipsychotic medications. For R131 the facility did not consistently document accurate urinary status. Findings include: Facility policy entitled Antipsychotic Medication Use (last revised 4/2007) stated that nursing staff will document in detail an individual's target symptom(s) and staff will observe, document and report to the attending physician information regarding the effectiveness of any interventions. A Behavior Monthly Flowsheet and Side Effects Monthly Flowsheet (both dated 7/13) were attached to the policy. 1a. R1's physician order dated 6/15/15 listed an antipsychotic medication to be given twice a day. Review of R1's Behavior and Side Effects Monthly Flowsheets for June and July, 2015 showed documentation started when the antipsychotic medication was ordered for R1's delusions and hallucinations. The following missing entries were discovered: * June : missing 15 out of 50 shifts of behavior monitoring and 18 out of 50 shifts of side effects	F 514	F 514 A. 1a. For Resident R1, the Behavior Monitoring and Flow Sheet is in place and there are no missing entries since 9/1/2015. B. All residents have the potential to be affected by this practice. C. All LPN and RN Nursing Staff to be in serviced by Staff Development for Behavior Monitoring and Flow Sheets, Documenting amount of bed time snacks, and documenting accurate urinary status. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT U. D. Random audits to be conducted for Behavior Monitoring and Flow Sheets and Documenting Consumption of Bed Time Snacks. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the random audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENTS V and W.	11/3/15

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F 514	Continued From page 22 * July: missing 11 out of 93 shifts of behavior monitoring and 18 out of 93 shifts of side effects 1b. R1's care plan problem entitled endocrine system related to insulin dependent diabetes (initiated 5/22/12 and reviewed quarterly throughout the stay at the facility) included the following interventions: observe for signs of high or low blood sugar; record percent of meals eaten, report to nurse if under 50% eaten. MAR entry dated 9/10/14 stated bedtime snack daily - record percent eaten with a scheduled time of 8:00 PM. Since R1's physician order dated 2/12/15 stated she was to receive a mix of long and short acting insulin twice a day, it is important that the resident eat a substantial bedtime snack to reduce the chance of her having an abnormally low blood sugar in the middle of the night that would require treatment. Review of R1's MAR for May, June and July, 2015 found different results on the nurse and CNA documentation for the percent of bedtime snack eaten. Percent eaten rated higher by the nurse: May: 2 out 31 days June: 8 out of 30 days July: 9 out of 31 days Percent eaten rated higher by the CNA: May: none in May however CNA entry missing on 5/9/15 June: 12 times out of 30 days however nurse entry missing on 6/26/15 July: 5 out of 31 days however CNA entry missing on 7/4/15	F 514	F514 A. 1b. For Resident R1, the amount of bed time snack consumed has been accurately documented since 9/1/2015. B. All residents have the potential to be affected by this practice. C. All LPN and RN Nursing Staff to be in serviced by Staff Development for Behavior Monitoring and Flow Sheets, Documenting amount of bed time snacks, and documenting accurate urinary status. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT U. D. Random audits to be conducted for Behavior Monitoring and Flow Sheets and Documenting Consumption of Bed Time Snacks. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the random audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENTS V and W.	11/3/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2015
NAME OF PROVIDER OR SUPPLIER PINNACLE REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977	

(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 514	Continued From page 23	F 514	F514	
	Several Interviews with E6 (UM) were conducted on 8/25/15 to confirm the difference between what the nurse and CNA documented for the amount of R1's bedtime snack. At 9:48 AM E6 stated that the CNAs deliver and assist with snacks. If the amount the resident eats is low the nurse could give additional snack items to the resident later which would cause the nurse percentage to be higher than the CNA. At 11:17 AM E6 stated that when the CNA documented the resident as eating more of the snack than the nurse, there was not good communication between the CNA and the nurse and that the nurse was not aware of the amount of snack eaten with CNA assistance.		A. 2. For resident R46, behavior and side effects for antipsychotic medications are being consistently documented. B. All residents have the potential to be affected by this practice. C. All LPN and RN Nursing Staff to be in serviced by Staff Development for Behavior Monitoring and Flow Sheets, Documenting amount of bed time snacks, and documenting accurate urinary status. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT U. D. Random audits to be conducted for Behavior Monitoring and Flow Sheets and Documenting Consumption of Bed Time Snacks. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the random audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENTS V and W.	11/3/15
	The facility failed to consistently document the amount of bedtime snack eaten by this resident with diabetes. 2. Review of R46's June, 2015 Behavior and Side Effects Monthly Flowsheets showed missing documentation for 7 shifts out of 90 shifts of behavior monitoring and 27 shifts out of 90 shifts of side effects. The facility failed to consistently document behavior and side effects for antipsychotic medications for two residents. 3. The following Skilled Documentation Notes (Nursing) were documented in R131's electronic clinical record related to his urinary status. R131 was re-admitted on 6/23/15 with a foley catheter after being in the hospital.			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085020		08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(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 514	Continued From page 24 Indwelling catheter present on nursing notes dated: 6/26-28/15, 7/1/15, 7/3/15, 7/6-10/15, 7/14, 7/16-18/15, 7/20-24/15, 7/26-28/15, 8/2/15, 8/4/15. Indwelling catheter not documented, but incontinence was documented in nursing notes dated: 6/25/15, 6/29/15, 7/2/15, 7/13/15, 7/19/15, 7/29-30/15, 8/3/15, 8/5/15, 8/6/15. Documentation stated R131 was continent of urine in nursing notes dated: 6/30/15, 7/4-5/15, 7/11-12/15, 7/17-18/15 (documentation on 7/17-18/15 also indicates R131 had an indwelling catheter). The facility failed to ensure accurate documentation due to inconsistencies with R131's urinary status since a person with an indwelling catheter can not be either continent or incontinent. These findings were reviewed with E1, NHA and E2, DON on 8/25/15 at 2:30 PM.	F 514	F 514 A. 3. For Resident R131, urinary status has been corrected and accurately documented. B. All residents have the potential to be affected by this practice. C. All LPN and RN Nursing Staff to be in serviced by Staff Development for Behavior Monitoring and Flow Sheets, Documenting amount of bed time snacks, and documenting accurate urinary status. The frequency of training will be determined by the identified trends in the audits in Element D. ATTACHMENT U. D. Random audits to be conducted for Behavior Monitoring and Flow Sheets and Documenting Consumption of Bed Time Snacks. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the random audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENTS V and W.	11/3/15

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Health and Rehabilitation Center

DATE SURVEY COMPLETED: August 25, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced annual survey was conducted at this facility from August 17, 2015 through August 25, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 141. The stage two survey sample was thirty-seven (37).	Cross Reference POC for CMS 2567L survey completed August 25,2015, Tags: F225,F241,F242, F253, F272,F279,F280, F309,F315,F323, F368, F463, and F514 Completion Date: November 3, 2015	11/3/15
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed August 25, 2015 F225, F241, F242, F253, F272, F279, F280, F309, F315, F323, F368, F463, F514		

Provider's Signature _____ Title _____ Date 10/14/15