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

PRINTED: 08/07/2015
FORM APPROVED
OMB NO. 0938-0391

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		C 07/30/2015

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 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from July 22, 2015 through July 30, 2015. The facility census on the entrance day of the survey was 139. The survey sample was composed of 4 residents. The survey process included observations, interviews and review of clinical records, facility documents and facility policies and procedures. Abbreviations used in this 2567 are as follows: DON - Director of Nursing; LPN - Licensed Practical Nurse; RN - Registered Nurse; CNA - Certified Nurse's Aide; NHA - Nursing Home Administrator; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Incontinence - loss of control of bowel and bladder function; cognition - thinking; dementia-severe cognition impairment characterized by memory loss.	F 000	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	9/15/15
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 clinical record review and staff	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X8) DATE: 8/13/15

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 309	Continued From page 1 interview it was determined that the facility failed to ensure that 2 residents (R1 and R3) out of 4 sampled received the necessary care and services to attain and maintain the highest practicable, physical, mental and psychological well-being in accordance with their respective plans of care. The facility failed to ensure that a physician order prescribed for R1 was implemented in a timely manner. Additionally the facility failed to provide incontinence care every two hours for R3. Findings include: 1. R1 had diagnoses of dementia, end-stage kidney disease (disease where kidneys stop working) and obstructive uropathy (a disorder involving the urinary tract). Review of the annual MDS dated 6/12/2015 and the MDS, completed on 7/13/2015 upon readmission to the facility, revealed that R1 displayed moderately impaired cognition. The annual MDS dated 6/12/2015 further revealed that R1 was receiving hemodialysis (a procedure that removes waste and extra fluids from the body). Clinical record review also revealed a nurse's note dated 10/28/2014 and timed 5:59 PM that stated R1 was scheduled for an insertion of a graft (an artificial tube used to make a connection between an artery and vein for hemodialysis) in her right upper arm under general anesthesia on 12/19/2014. P2 (surgeon) ordered results of medical clearance for R1 by P1 (primary physician) prior to the actual graft procedure. However another nurse's note dated 11/19/2014 and timed 10:09 AM revealed that R1's graft procedure was postponed on 12/19/2014 without any documented explanation and rescheduled for 1/9/2015.	F 309	F309 A. R1 appointment was rescheduled with the appropriate paper work and R1 received procedure without incident. B. All residents have the potential to be affected by this practice. Since the end of the survey, residents requiring medical procedures had the proper medical clearance in place. C. All scheduled surgical procedures are reviewed at morning clinical meeting to ensure proper clearance is in place. D. An audit to be performed daily by QA Nurse for 1 month until 100% success is achieved. Results of the audits will be submitted to the QA committee. The QA will determine the need for further submissions. ATTACHMENT A	9/15/15

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F 309	Continued From page 2 Further review of the clinical record revealed a nurse's note dated 1/8/2015 at 3:00 PM that stated "...P2's office called...needed a medical clearance for R1's graft procedure on 1/9/2015." This information was relayed to P1 (primary physician). Another nurse's note dated 1/8/2015 and timed 6:32 PM stated that the graft procedure was canceled "because P1 faxed a prescription to P2's office instead of medical clearance" for R1. In an interview conducted with E3 (LPN) on 7/30/2015 at 12:12 PM it was stated that P1 documented "medical clearance" for R1 on a facility "Telephone Order" form dated 10/29/2014 and faxed it to P2's office. However the order form was not accepted by P2 who canceled the graft procedure scheduled for 1/9/2015. According to a nurse's note on 1/9/2015 at 12:30 PM P1's office contacted the facility and rescheduled R1 for a graft procedure on 2/13/2015. The facility was reminded that medical clearance for R1 was required to be typed on facility letterhead paper for acceptance. Despite acceptance of a completed medical clearance for R1 dated 1/9/2015, the graft procedure rescheduled for 2/13/2015 was canceled due to hospitalization of R1 on 2/10/2015. A nurse's note documented 3/27/2015 at 12:28 PM revealed that R1 had received a graft in the right upper arm and returned to the long-term care facility at 1:45 PM of the same date, 3/272015. The facility failed to ensure that all orders were completed in a timely manner to provide the necessary care and services required to attain and maintain the highest practicable physical, mental, and psychosocial well-being of R1 in accordance with the physician's plan of care. These findings were reviewed with E1 (NHA) and	F 309		9/15/15

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F 309	Continued From page 3 E2 (DON) on 7/30/2015 at 3:30 PM. 2. Clinical record review revealed that R3 had diagnoses which included peripheral vascular disease, cerebrovascular accident (stroke) and hemiplegia/ hemeparesis (paralysis/slight paralysis affecting only one side of the body). According to the annual MDS dated 9/4/2014 and the quarterly MDS dated 5/14/2015 R3 was cognitively intact. Further review of the above referenced MDS also revealed that R3 was incontinent of bowel and bladder and dependent upon two staff members for transfer and hygiene. Although the same two MDS assessments revealed that no ambulation occurred in her room or on the unit corridor, R3 was dependent on the physical assistance of one staff member for locomotion on her nursing unit. Review of an investigation conducted by the Division of Long Term Care Residents Protection (DLTCRP) revealed that the facility failed to provide incontinent care between 3:00 PM and 9:30 PM for R3 during the 3-11 shift on 3/24/2015. In an interview conducted on 7/29/2015 with E4 (CNA) at 1:20 PM she confirmed that she did not ask or administer incontinent care to R3. E4 further stated that she is aware that R3 is alert and oriented to time, place and person and expected R3 to ask for incontinent care when she needed it. E4 also stated that she did not review the CNA book for the care of R3 before beginning her assignment on the the 3-11 shift, 3/24/2015. However she stated on a previous assignment she had assisted with the care of R3 and heard R3 ask for incontinent care when needed. Since the incident E4 states she provides R3 incontinent care every two hours.	F 309	F309 A. R3 received incontinent care. Skin checks were performed and no issues were noted. B. All residents have the potential to be affected by this practice. Facility wide audit to be completed and care tracker to be updated to reflect resident care needs. C. Educate Direct Care Nursing Staff on properly utilizing care tracker to determine resident care needs. ATTACHMENT B D. Daily audit by QA Nurse of Care Tracker system to ensure direct care staff is utilizing the tool for identifying resident care needs. The audit will be done daily for 1 month until 100% success is achieved. Results of the audits will be submitted to the QA committee. The Quality Improvement Committee will determine the need for further submissions. ATTACHMENT C	9/15/15

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F 309	Continued From page 4 In an interview conducted with E2 on 7/28/2015 at approximately 3:30 PM it was stated that E4 was counseled regarding the provision of care and services to R3. These findings were reviewed with E1 (NHA) and E2 on 7/30/2015 at 3:30 PM.	F 309		9/15/15

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 Rehabilitation and Health Center **DATE SURVEY COMPLETED: July 30, 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 complaint survey was conducted at this facility from July 22, 2015 through July 30, 2015. The facility census on the entrance day of the survey was 139. The survey sample was composed of 4 residents. The survey process included observations, interviews and review of clinical records, facility documents and facility policies and procedures.		
3201	**Regulations for Skilled and Intermediate Care Facilities**	**Cross Reference POC for CMS 2567L survey completed July 30, 2015 F-Tags: F309**	
3201.1.0	**Scope**	**Completion Date September 15, 2015**	
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 July 30, 2015 --F309		

Provider's Signature _____ Title Administrator Date 8/13/15