

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

PRINTED: 10/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/21/2012
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NAME OF PROVIDER OR SUPPLIER  SHIPLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810
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F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law.	
F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to</p>	F 156	<p>F156</p> <p>1. R69 and R122 no longer reside at the facility.</p> <p>2. An audit by NHA or designee of all residents discharged and/or change in benefit status in the previous 6 months will be audited for compliance with policy, "ABN Policy Procedure: Expedited Process"</p>	11/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kendy L. Ruad, NHA</i>	TITLE <i>EXECUTIVE DIRECTOR</i>	(X6) DATE <i>10/17/12</i>
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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 156	<p>Continued From page 1</p> <p>the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the</p>	F 156	<p>3. The Social Services Director will receive education regarding "ABN Policy Procedure: Expedited Process" by NHA or designee. A weekly discharge and/or benefit change audit will be conducted by NHA/DON or designee of all discharged resident to ensure compliance with "ABN Policy Procedure: Expedited Process". Variances to the policy will be immediately corrected.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>	

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F 156	<p>Continued From page 2</p> <p>facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide the "Right to Appeal Notice" to two (R69 and R122) of three residents discharged from the facility. Findings include:  The facility policy entitled: "ABN Policy Procedure:</p>	F 156		

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F 156	<p>Continued From page 3</p> <p>Expedited Process" was reviewed. "Fundamental information" documented, "the notice should be given only when the resident will no longer receive any Medicare covered services...The Generic Notice, 1). must be issued two days in advance of coverage termination.....The generic notice must be given in all applicable situations, regardless of whether the beneficiary agrees that services should end". The policy also included that "no notice is required when a resident elects to terminate Medicare coverage" and that "Notice Required when all covered services provided under Part A are terminated where the resident has remaining SNF days available and when the resident simultaneously ends coverage under Part A and discharged from the facility".</p> <p>1. Review of facility records for R69 revealed that the "Right to Appeal Notice" was not provided when the resident left the facility.</p> <p>In an interview with E6 (Social Service Director) on 9/20/12 at 11:29 AM, she stated that she did not provide the "Right to Appeal Notice" to R69. E6 stated, "There is no cut letter for R69, R69 was admitted on 3/21/12, was discharged home on 4/20/12, was here for short term therapy, and R69 did not get a cut letter".</p> <p>2. Review of facility records for R122 revealed that the "Right to Appeal Notice" was not provided when R122 left the facility.</p> <p>In an interview with E6 (Social Service Director) on 9/20/12 at 11:35 AM, she stated that she did not provide the "Right to Appeal Notice" to R122. E6 stated that for R122, the "Resident was admitted to the facility on 3/27/12 and was</p>	F 156		

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F 156	Continued From page 4 discharged on 4/12/12 ...R122 was admitted and shortly after he got here, the family wanted R122 to go home to another facility". She stated he did not get a cut letter and confirmed R122 should have received a cut letter.	F 156	F166 1. R1 no longer resides at the facility and was discharged with the found pajamas.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve a grievance for one (R1) out of 37 Stage 2 sampled residents. Findings include:  1. An interview with R1 on 9/11/12 at 11:05 AM revealed the resident lost a pair of pajamas shortly after being admitted to the facility, approximately two to four weeks ago. R1 stated that she reported it to numerous facility staff, but could not remember who she told and that the pajama set was never returned.  In an interview with E6 (Social Service Director) on 9/19/12 at 11:30 AM, she stated that she was not aware of R1's missing pajamas and that there was no concern form/incident report on file.  Later in the day on 9/19/12 at 2:16 PM, E6 presented the surveyor with a copy of a concern form (dated 9/19/12) which stated that the pajamas were found and returned to R1. She	F 166	2. All residents who experience lost or misplaced possessions have the potential to be affected by the same practice. An audit by interview by Director of Social Services and/or designee with all residents currently residing at the facility will be conducted to determine and ensure that all grievances of lost or misplaced resident possessions are reported, documented, and timely investigated to conclusion. Any variance to the standard will be immediately corrected.  3. Education will be provided to all facility staff regarding resident grievances and reporting requirements to ensure timely reporting, documentation and investigation are conducted expeditiously for a conclusion. A weekly audit by the NHA or designee will be conducted of resident grievances for lost or misplaced possessions to ensure that reporting, documentation, and investigation are conducted timely.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	11/6/12

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F 166	Continued From page 5 stated that the pajamas were found in the facility's laundry lost and found hamper.  The facility failed to act upon a concern brought forth by R1 in a timely manner, failed to complete a concern form when informed by R1 of the missing pajamas, and failed to conduct a search for the pajamas at the time that it was reported.	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to promote care for 7 (R5, R22, R66, R88, R115, R116, and R147) out of 37 stage 2 sampled residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include:  1. On 9/11/12 at approximately 5:01 PM, this surveyor was conducting a resident interview with R5 in his room with the door closed. E12 (nurse) knocked on R5's door, but failed to wait to receive permission to enter.  2. On 9/11/12 at approximately 3:29 PM, this surveyor was conducting a resident interview with R66 in her room with the door closed. E12 (nurse) knocked on R66's door, but failed to wait to receive permission to enter. Upon entering the	F 241	F241  1. The Director of Social Service will interview each resident (R5, R22, R66, R88, R115, R116 and R147) to ensure no lasting effect of stated occurrences.  2. E12 and E13 have received education regarding proper resident room entry that promotes dignity and respect. A dining services audit will be conducted daily for all 3 meals by Food Services Director or designee to ensure that dining standards for table service is achieved which demonstrates a dignified dining experience whereby residents who are seated together are served together. An observatory random audit of 5 occurrences will be conducted daily by DON or designee for proper resident room entry by staff which promotes dignity and respect.	11/16/12

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F 241	Continued From page 6 room, E12 stated to the surveyor "I keep walking in on you." This surveyor responded that I had not heard her requesting permission to enter, to which she responded, "But I did knock."  3. On 9/18/12, E14 (Certified Nurse Aide-CNA) and E15 (CNA) were observed providing morning care for R147 between 10:40 AM through 11:30 AM. R147's door was closed while care was provided. At approximately 11:20 AM, E13 (CNA) entered R147's room. E13 failed to knock and request permission to enter the room.  4. On 9/11/12, observation of the midday meal was conducted. R115 was observed seated at a table with R27 and R116. At 12:53 PM, R27 was served her entree. R115 sat and watched R27 eat and was not served her entree until 1:04 PM, a total of 15 minutes later. The facility failed to provide dining for R115 in a dignified manner.  5. On 9/11/12, observation of the midday meal was conducted. R116 was observed seated at a table with R27 and R115. At 12:53 PM, R27 was served her entree. R116 sat and watched R27 eat and was not served his entree until 1:04 PM, a total of 15 minutes later. The facility failed to promote care to R116 in a dignified manner during dining.  6. On 9/11/12, observation of the midday meal was conducted. R88 was observed seated at a table with R162 and R22. At 12:54 PM, R162 was served her entree. R88 sat and watched R162 eat and was not served her entree until 1:05 PM, a total of 15 minutes later. The facility failed to promote care to R88 in a dignified manner during dining.	F 241	3. Education will be provided to all Food Service staff regarding table service standards which include the process whereby all residents seated at the same table will have their meals served in unison. The Food Service Director or designee will conduct a weekly audit of dining services for dignified table service to ensure proper table service is achieved and maintained. Any variance to the defined standard will be immediately corrected. Education will be provided to all staff regarding resident room entry procedure which promotes resident dignity and respect. The DON or designee will conduct weekly random audits of at least 5 occurrences to ensure staff enter resident rooms in a manner that promotes dignity and respect.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.		

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F 241	Continued From page 7  7. On 9/11/12, observation of the midday meal was conducted. R22 was observed seated at a table with R162 and R88. At 12:54 PM, R162 was served her entrée. R22 sat and watched R162 eat and was not served her entree until 1:05 PM, a total of 15 minutes later. The facility failed to promote care to R22 in a dignified manner during dining.  Findings regarding dining concerns were reviewed with and acknowledged by E1 (Administrator), E2 (Director of Nursing) and E4 (Corporate Nurse) during an interview on 9/21/12 at 11:45 AM.	F 241	F246  1. R147 still resides at the facility and the resident's call bell has been maintained within reach. R160 no longer resides at the facility.	11/6/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and 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 observations and interviews, it was determined that the facility failed to ensure that two (R147 and R160) out of 37 sampled residents had reasonable accommodation of their needs. The facility failed to ensure that R147's and R160's call bells were within reach. Findings include:  1. During a resident interview on 9/11/12 at 2:00	F 246	E16 has received education regarding resident call bell placement.  2. An audit was conducted of all call bells to ensure proper placement and function with no variances identified.  3. All staff will receive education regarding reasonable accommodation of residents' needs/preferences, specific to call bells within reach. A daily audit, varying in time of day, will be conducted by DON or designee of residents' call bells to ensure that they are within residents' reach.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	

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F 246	Continued From page 8 PM, R160 was determined to be alert and oriented to person, place and time.  After completion of the interview at approximately 2:13 PM, R160's call bell was clipped to the top of her pillow at the top of her bed. R160 was seated in a wheelchair off to the side of the bed. When asked if she was able to reach her call bell should she need it, R160 tried to get to it but stated she was not able to reach it. E16 (CNA) was called into the room and acknowledged that R160 was not able to reach the call bell and then placed it within R160's reach.  2. R147's most recent quarterly Minimum Data Set (MDS) assessment, dated 9/5/12 stated this resident's vision was highly impaired.  On 9/18/12 at 10:35 AM, R147 was observed lying in bed with her call bell on the floor. E14 (CNA) entered the room and was shown the call bell on the floor. E14 acknowledged the call bell was out of R147's reach.	F 246		
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 staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations were made of	F 253		

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F 253	<p>Continued From page 9</p> <p>a dirty toilet and dirty wheelchairs, and of two pipes from a vent system protruding out of a resident's room wall. Additionally, a wet carpet was observed in the hallway. Findings include:</p> <p>1. Observation of the wall in resident room #508B on 9/18/12 at 11:13 AM revealed two 1/4 inch pipes protruding out of the wall on the window side. The wall was also in disrepair. R23 was observed at this same time, seated in her wheelchair next to the foot of her bed. R23 was asked about the protruding pipes, and she stated that the heater was replaced about a month ago. She stated that she was unsure why the pipes were left that way.</p> <p>In an interview with E18 (CNA) on 9/18/12 at 11:19 AM, she stated that she was not aware the pipes were protruding out from the wall and that it was up to maintenance to fix the pipes. She stated she would bring the concern up to maintenance as soon as possible.</p> <p>Immediately after E18 left the room on 9/18/12 at 11:25 AM, E3 (ADON) and E7 (RN Supervisor) were observed in R23's room and confirmed this finding. E7 stated "E8 (Maintenance Director) was on his way".</p> <p>In an interview with E8 on 9/18/12 at 11:27 AM, he revealed that the pipes needed to be covered with a box and was observed calling another maintenance staff to place a box on the unit.</p> <p>2. A dirty toilet was observed in resident room 504 on 9/11/12 at 10:30 AM and 3:15 PM, on 9/14/12 at 10:39 AM, and again on 9/17/12 at 11:13 AM and 12:30 PM.</p>	F 253	<p>F253</p> <p>1. Immediate correction was made on 9/18/2012 to R23's room with a box securely mounted to the wall, covering the protruding pipes. Repairs were made to the wall. Room 504's toilet was cleaned with education provided to staff identified. During the temporary episodes of loose stools of the resident, the bathroom was inspected every 2 hours by the RN Supervisor to ensure cleanliness was achieved and maintained. Wheelchairs for residents in rooms 512B, 515B, and 715 were cleaned on 9/20/2012. The hallway carpet in front of the first floor kitchenette/pantry was wet and properly identified with a "wet floor" sign, beginning on 9/11/2012 when the refrigerator had begun to leak due to a condensate valve malfunction. The repair vendor, Ecolab Equipment Care, had been immediately notified and responded on 9/11/2012, identifying that the part needed to stop the leak would need to be ordered with an expected delivery for repair on 9/17/2012. On 9/17/2012, E8 was notified that the ordered part was "back ordered" and would not be available for proper repair until 9/22/2012. On 9/22/2012, the part was received and the leak repaired. Proper carpet cleaning was accomplished and this area is no longer wet.</p>	11/6/12

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/21/2012
NAME OF PROVIDER OR SUPPLIER  SHIPLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810		
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F 253	Continued From page 10  In an interview with E19 (CNA) on 9/11/12 at 3:15 PM, he confirmed the toilet was dirty and stated he would get someone to clean it. Again, on 9/14/12 at 10:39 AM in an interview, E20 (CNA) confirmed the toilet was dirty. E20 stated that the resident had loose stools and that housekeeping would clean it.  3. Dirty wheelchairs were observed for residents in room 512B, 515B and 715.  In an interview with E8 on 9/19/12 at 2:30 PM, he confirmed this finding. E8 stated that they clean wheelchairs every month and he would get wheelchairs cleaned tomorrow.  4. Observations made throughout the survey (from 9/11/12 to 9/21/12) revealed the hallway carpet in front of the first floor kitchenette/pantry was wet and water stained.  In an interview with E8 on 9/21/12 at 12:01 PM, he confirmed this finding. E8 stated that he was getting the refrigerator in the pantry repaired, as it was leaking water onto the hallway carpet.	F 253	2. An audit was conducted on 9/18/2012 of all resident rooms to ensure that there were no uncovered protruding pipes and walls in disrepair. No other variances were identified. An inspection of all resident bathrooms was conducted on 9/17/2012 with no other cleanliness variances identified. A daily audit by the Housekeeping Supervisor or designee will be conducted to ensure that resident bathroom cleanliness standards are achieved and maintained. An audit was conducted on 9/19/2012 of all resident wheelchairs and no other wheelchairs were identified, no other residents were affected.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the	F 278			

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F 278	<p>Continued From page 11 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 by: Based on record review and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status for three (R85, R67 and R161) out of 37 stage 2 sampled residents. R85 was not coded for antianxiety use on the 9/4/12 quarterly MDS. R67 was incorrectly coded on the 7/3/12 significant change MDS for risk for pressure ulcer. R161's Admission MDS on 9/11/12 was incorrectly coded for pain and for a swallowing disorder. Findings include:</p> <p>1. R85's August 2012 POS (Physician's Order Sheet) included a physician's order that stated, "Lorazepam (anxiolytic) 0.5 mg (milligrams) tablet</p>	F 278	<p>3. Education will be conducted with all facility staff regarding proper reporting of observed maintenance and housekeeping variances (resident room safety, bathroom cleanliness, wheelchair cleanliness). A weekly audit will be conducted by the NHA or designee of maintenance and housekeeping standards for safety and cleanliness (resident room safety, bathroom cleanliness, wheelchair cleanliness). A daily audit by the Housekeeping Supervisor or designee will be conducted to ensure that resident bathroom cleanliness standards are achieved and maintained. A weekly audit will be conducted by the Housekeeping Supervisor or designee of all resident wheelchairs to ensure achievement of cleanliness standards and compliance with scheduled cleaning. Any identified variances will be immediately corrected.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>		

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F 278	<p>Continued From page 12</p> <p>- Take 1 tablet by mouth every 8 hours as needed for anxiety".</p> <p>R85's 8/12 MAR (Medication Administration Record) revealed that R85 received one dose of Lorazepam on 8/30/12 at 11:15 PM for complaints of anxiety.</p> <p>Review of R85's Quarterly MDS assessment, dated 9/4/12, under section N0400 for "Medications Received" in the last 7 days, only indicated antidepressant and diuretic use.</p> <p>During an interview on 9/19/12 at 12:15 PM, E7 (nurse supervisor) confirmed that the 9/4/12 quarterly MDS failed to code that R85 had received antianxiety medication in the prior 7 days. The facility failed to include the antianxiety medication that R85 received on 8/30/12 on the 9/4/12 quarterly MDS assessment.</p> <p>2 On 7/2/12, R67's Braden Scale score was 18, indicating the resident was "At risk" for the development of a pressure ulcer.</p> <p>R67 had a care plan entitled, "Potential for alteration in skin integrity r/t (related to) mobility, medications, and dementia" which was developed 11/3/11 and last revised 6/28/12. Approaches included, "Weekly skin checks/daily observation by direct care staff, 2 people to pull up in bed to prevent shearing prn (as needed), offload heels as needed..."</p> <p>The significant change MDS, dated 7/3/12, in section "MO150 Risk of Pressure Ulcers" was incorrectly coded as "0" which indicated no.</p>	F 278	<p>F278</p> <p>1. An MDS correction has been made for each: R85, R67, and R161, on 9/19/2012 to accurately reflect the residents' status.</p>	11/6/12	

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F 278	<p>Continued From page 13</p> <p>The facility failed to accurately code R67's significant change MDS, dated 7/3/12, for the risk of pressure ulcers. On 9/20/12 at 4:05 PM in an interview, E3 (ADON) acknowledged the findings.</p> <p>3a. R161 was admitted to the facility on 9/4/12 with diagnoses including left hip fracture with ORIF (open reduction internal fixation surgery), Type II Diabetes and Alzheimer's Disease.</p> <p>Review of R161's Medication Administration Record (MAR) for 9/12, revealed R161's physician ordered, "Tylenol 650 mg po (orally) prior to rehab" (therapy) for pain. R161 received the Tylenol as ordered during the 5 day look back period. The pain assessment during day shift was scored 5 out of 10 on 9/7/12, 6 out of 10 on 9/8/12, 5 out of 10 on 9/9/12, and 2 out of 10 on 9/11/12.</p> <p>Review of the nurses' notes (NN), dated 9/7/12 - 9/11/12, revealed evidence of pain with Tylenol use for R161.</p> <p>The admission MDS, dated 9/11/12, was incorrectly coded in section J, pain. "J0100 Pain Management" was incorrectly coded as "0" which indicated none for scheduled pain medication received. "J0800 Indicators of pain or possible pain" was incorrectly coded "Z. none of these signs observed or documented." "J0850 Frequency of indicator of pain or possible pain" was blank which indicated "none" which was inaccurate.</p> <p>3b. R161's admission MDS, dated 9/11/12, was incorrectly coded in section K0100, Swallowing Disorder which was checked "Z. None of the</p>	F 278	<p>2a. All residents currently on antianxiety medication have the potential to be affected by the same practice. The DON or designee will conduct an audit of all residents currently on antianxiety medications to ensure accurate coding on their most current MDS. Any assessment identified with coding inaccuracies will have their MDS corrected.</p> <p>2b. All residents at high risk for skin breakdown have the potential to be affected this same practice. The DON or designee will conduct an audit of all residents' skin assessment (Braden Scale) to identify high risk residents' proper coding on their most current MDS. Any assessment identified with coding inaccuracies will have their MDS corrected.</p> <p>2c. All residents have the potential to be affected by this same practice relating to proper coding for pain. The DON or designee will conduct an audit of all residents' most recent MARS (Medication Administration Record) to ensure proper coding of the MDS as it relates to the chart documentation regarding pain. Any assessment identified with coding inaccuracies will have their MDS corrected.</p>		

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F 278	Continued From page 14 above".  On 9/5/12, an order was written, "Clarification SLP (Speech Language Pathologist) eval/tx (evaluation/treatment) orders: 1. No straws, continue c (with) puree texture. 2. Tx 5xwk (5 days/week) x 45 days q (every) day to > (increase) swallow fxn (function)/airway protection and mastication (chewing)."  Review of the Dysphagia assessment by the SLP, dated 9/5/12, revealed that Dysphagia was the reason for the referral to skilled therapy. Clinical impressions included, "> (Increased) SOB (shortness of breath) c thins (thin liquids) via straw - congested cough when cued very weak, anterior leakage c thins". Prolonged mastication was noted on treatment by the SLP on 9/5/12 and 9/7/12.  The facility failed to accurately code R161's admission MDS, dated 9/11/12, in the areas of pain and swallowing disorder. On 9/19/12 at 2:15 PM in an interview, E5 (RNAC) acknowledged the findings.	F 278	2d. All residents with a speech therapy screening or speech therapy evaluation have the potential to be affected by the same practice. The DON or designee will conduct an audit of all residents' most current documentation for swallowing deficits for accuracy of MDS coding. Any assessment identified with coding inaccuracies will have their MDS corrected.  3. Education will be conducted with the MDS Coordinator regarding accurate MDS coding for antianxiety use, potential for skin breakdown, pain, and swallowing deficits. The DON or designee will conduct random weekly audits of 3 MDSs to monitor proper/accurate MDS coding for antianxiety, potential for skin breakdown, pain, and swallowing deficits. Any assessment identified with coding inaccuracies will have their MDS corrected.		
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.	F 279	4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.		

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F 279	Continued From page 15  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: Based on closed record review and interview, it was determined that the facility failed to develop a comprehensive care plan for an identified need for two (R10 and R89) out of 37 stage 2 sampled residents. For R10, no care plan was developed when the resident became incontinent of bladder. For R89, no care plan was developed when the resident was both continent and incontinent of bladder. Findings include:  1. Cross refer F315 example #1 The Significant change MDS, dated 4/21/12, was coded "1" for bladder continence which indicated that R10 was occasionally incontinent, less than 7 episodes of incontinence and the toileting program was coded "0", which indicated none. R10's functional status was coded as "3/3", extensive assistance/two + persons in the areas of bed mobility and transfer; as "3/2", extensive assistance/one person in the areas of locomotion on and off the unit, dressing and toilet use; as "2/2", limited assistance/one person in the areas of walk in room and corridor and hygiene.	F 279	F279  1. R10 and R89 no longer reside at the facility.  2. An audit will be conducted by DON or designee of all residents' current continence status and ensure accurate comprehensive care plans are developed which reflect measurable goals and interventions to address the care and treatment related to services to restore as much bladder function as possible. Variances will be immediately corrected.  3. All certified and licensed staff will receive education regarding comprehensive care planning for urinary incontinence and individualized approaches identified to restore as much bladder function as possible. The DON or designee will conduct a monthly care plan audit for accuracy and implementation of the measurable goals and interventions to address the care and treatment related to services to restore as much bladder function as possible for each resident. Variances will be immediately corrected.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	11/6/12	

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F 279	<p>Continued From page 16</p> <p>The Care Area Assessment (CAAs) Summary, dated 4/27/12, was triggered and checked for care plan decision in the area of urinary incontinence.</p> <p>Despite a decline in urinary continence and the CAA for urinary incontinence being triggered and checked for care plan development, record review lacked evidence of development of an incontinence care plan.</p> <p>On 9/21/12 at 2:20 PM in an interview, E2 (DON) acknowledged that no urinary incontinence care plan was developed.</p> <p>The facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment related to services to restore as much bladder function as possible for R10.</p> <p>2. Cross refer F315, example #2 R89 was admitted to the facility on 5/31/12. The 6/7/12 admission Minimum Data Set (MDS) assessment stated that R89 was coded a "2" for bladder ("2" = 7 or more episodes of urinary incontinence, but at least one episode of continent voiding). This MDS's Care Area Assessment (CAA) Summary triggered incontinence as a problem area and was checked off to proceed with care planning.</p> <p>Although the facility incorporated the intervention to "assist to the toilet as needed" and "incontinence care each round," into the care plan for potential for alteration in skin integrity, the facility failed to develop an individualized care plan for R89's incontinence.</p>	F 279			

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F 279	Continued From page 17	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise and individualize care plans for 3 (R10, R28, and R147) out of 37 stage 2 sampled residents. Findings include:</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> <li>R10, R28, and R147 no longer reside at the facility.</li> <li>An audit will be conducted by DON or designee of all residents' care plans to ensure individualized approaches are accurately documented for bowel and bladder continence and oral care reflecting each resident's individualized status and needs. Variances will be immediately corrected.</li> <li>Licensed and certified staff will receive education regarding individualized interdisciplinary care plans. An audit will be conducted by the DON or designee of 5 interdisciplinary care plans per week to ensure residents' individualized care plan goals accurately reflect the care and services provided. Variances will be immediately corrected.</li> <li>Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</li> </ol>	11/16/12

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F 280	<p>Continued From page 18</p> <p>1. R28 was readmitted to the facility on 8/14/12. R28's Significant Change MDS (Minimum Data Set) assessment, dated 8/20/12, was coded as "none of the above" under "Oral/Dental Status". Additionally, R28's quarterly MDS, dated 6/11/12 did not reveal any problems for oral/dental status or indicate that R28 had dentures.</p> <p>Review of R28's care plan, dated 7/2/12 and reviewed/revise on 8/14/12 and entitled, "Dental Care has own teeth" listed approaches that included, "...8. mouth care q (every) AM/ Q PM and PRN (as needed)... 10. soak dentures Q hs (night), 11. apply polident pm." However, as stated on R28's care plan and MDS, R28 did not have dentures.</p> <p>During an interview on 9/21/12 at 9:35 AM, E7 (nurse supervisor) reviewed the "CNA (Certified Nurse Aide) Care Card" which indicated that R28 had "Some/all natural teeth" and had no indication for partial or full dentures. She confirmed that R28 did not have dentures. E7 acknowledged that R28's care plan for Dental Care was not accurate.</p> <p>The facility failed to individualize the preprinted care plan by discontinuing the inappropriate approaches regarding denture care.</p> <p>2. R10's admission Minimum Data Set Assessment (MDS), dated 2/27/12, and the readmission MDS, dated 4/6/12, both coded bladder and bowel continence as "0" which indicated that the resident was always continent.</p> <p>The care plan entitled, "Potential for Alteration in Skin Integrity related to decreased mobility,</p>	F 280		

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F 280	<p>Continued From page 19</p> <p>decreased po (oral) intake, medication and pain, P/F (potential for) unavoidable as metastasis progresses" was developed 2/20/12 revised 3/30, 4/14/12. Approaches included, "Assist to toilet as needed, incontinence care each round..." However, incontinence care was an inappropriate intervention/approach since R10 was continent of bladder and bowel on admission.</p> <p>The care plan entitled, "Urinary Tract Infection", was developed on 2/20/12, revised on 3/30/12 and discontinued on 4/14/12. Approaches included, "Administer Levaquin (antibiotic)..., encourage fluids, incontinence care each round..." However, incontinence care was an inappropriate intervention/approach since R10 was continent of bladder and bowel on admission.</p> <p>On 9/21/12 at 2:20 PM in an interview, E2 (DON) acknowledged that the care plans were inaccurate with an intervention of incontinent care when R10 was continent and should have been revised.</p> <p>The approach for the Potential for Alteration in Skin Integrity and Urinary Tract Infection care plans failed to be revised to reflect R10's continent urinary and bowel status.</p> <p>3. R147's 6/12/12 admission Minimum Data Set (MDS) assessment stated the resident had no dental issues. Observation of and interview with R147 on 9/11/12 at 4:10 PM revealed she had her natural teeth and did not have dentures.</p> <p>Review of a care plan developed by the facility on 6/5/12 for "Dental Care 'Natural teeth'..." revealed</p>	F 280	

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NAME OF PROVIDER OR SUPPLIER  <b>SHIPLEY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2723 SHIPLEY ROAD WILMINGTON, DE 19810</b>		
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F 280	Continued From page 20 the approaches listed included "...soak dentures every bedtime" and "apply polident as needed." R147 did not have dentures.  The facility utilized a generic dental care plan and failed to review and revise it to reflect R147's individualized dental needs. During an interview with E2 (DON) on 9/21/12 at 11:00 AM, she acknowledged that the interventions on R147's dental care plan were not appropriate.	F 280			
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, interview and other facility documentation, it was determined that the facility failed to 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 for one (R27) out of 37 stage 2 sampled residents. The facility failed to monitor when R27 had no BMs for more than 3 days and failed to consistently implement the bowel protocol during 3/12 through 7/12. Findings include:  The facility policy and procedure entitled, "Bowel	F 309	F309  1. R27 remains clinically stable and experienced no affect by this practice. Documentation cannot be retroactively corrected.  2. All residents have the potential to be affected by this practice. An audit will be completed by the DON or designee of all resident bowel records for the previous 7 days to identify any potential constipation issues and bowel protocol will be initiated according to policy.	11/6/12	

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F 309	<p>Continued From page 21</p> <p>Protocol" stated, "1. If no bowel movement (BM) in 3 days give 30 ml of MOM (Milk of Magnesia). 2. If no results in 16 hours give 2nd dose of 30 ml of MOM. 3. If no results in 8 hours give Dulcolax suppository x 1 (once). 4. If no results in 8 hours give Fleets enema x1 (once). 5. If no results in 4 hours complete digital exam and notify NP (Nurse Practitioner or MD (Physician) of results."</p> <p>R27 was admitted to the facility on 2/28/12 and had diagnoses of metastatic abdominal cancer (CA) and dementia. Upon admission, R27's physician ordered Colace 100 mg orally twice a day, a stool softener and Roxanol (morphine) 5 mg every 4 hours as needed for pain, shortness of breath. On 3/5/12, R27's physician ordered Roxanol 5 mg every 8 hours routine. A side effect of Roxanol is constipation.</p> <p>A care plan entitled, "Potential for alteration in bowel related to abd.(abdominal) metastatic CA unknown etiology, &lt; (decreased) mobility, medication, &lt; po (oral) intake" was developed on 2/28/12 with the goal, "I will have a bowel movement at least q (every) 3 days thru next review". Approaches included, "Monitor for and document q shift for BM's. Monitor for s/s (signs/symptoms of) constipation... Bowel protocol. Encourage fluid and food consumption... Assist to toilet as needed. On 4/6/12, Constipation was identified as a problem on the care plan. An additional approach at that time included, "Senna 2 tab po q HS (bedtime), hold for loose stool".</p> <p>The Bowel Elimination Pattern Report was reviewed and revealed the following: 3/5 through 3/19/12, no BM for 15 days;</p>	F 309	<p>3. All Certified Nursing Assistants will be educated regarding documenting BM's in the Care Tracker (computerized documentation system) by DON or designee. All Licensed Nurses will be educated on retrieval of computerized bowel records on residents by DON or designee. All RN Supervisors will be educated by DON or designee on retrieval of computerized reports that indicate residents who have not had a BM in 9 previous shifts. All licensed staff will be educated regarding the bowel protocol. The DON or designee will audit BM reports daily to monitor bowel protocol initiation and follow through. Any variances will be immediately corrected.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>	

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F 309	<p>Continued From page 22</p> <p>4/7 through 4/14/12, no BM for 8 days; 4/17 through 4/21/12, no BM for 5 days; 4/23 through 4/28/12, no BM for 6 days; 5/14 through 5/19/12, no BM for 6 days; 5/21 through 5/27/12, no BM for 7 days; 6/1 through 6/5/12, no BM for 5 days; 6/7 through 6/10/12, no BM for 4 days; 6/15 through 6/24/12, no BM for 10 days; 7/1 through 7/6/12, no BM for 6 days; 7/12 through 7/16/12, no BM for 5 days; 7/18 through 7/25/12, no BM for 8 days; 8/2 through 8/5/12, no BM for 4 days.</p> <p>The physician progress note for R27, dated 3/5/12, "Asked to see pt 2 (secondary to) generalized pain, pt unable to verbalized (sic) character or location of pain...PRN Roxanol but unable to ask for it... + BS (positive bowel sounds) SNT (soft, non tender)... Chronic pain Will change Roxanol 5 mg po/sl q 8 hrs routine for pain - hold for sedation. Constipation - change Colace caps to liquid..."</p> <p>The physician progress note for R27, dated 4/16/12, "Asked to see pt 2 constipation, + hard stools, 0 N/V (no nausea/vomiting), denies abd pain...+ BS SNT ...Constipation - continue c (with) Colace. Add Senna 2 tab po (orally) q (every) HS (bedtime)..."</p> <p>Review of the record revealed that R27 was not hospitalized since admission and had not had abdominal xrays done at the facility.</p> <p>On 8/8/12, R27's physician, discontinued Senna at HS and ordered Senna S 2 tablets daily which were administered at 9 PM. Use of the Serina S resulted in R27 having regular bowel elimination</p>	F 309		
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F 309	<p>Continued From page 23</p> <p>of one BM every three days more frequently from 8/9/12 through 9/19/12.</p> <p>On 9/20/12 at 11 AM in an interview, E41 (LPN) was asked about how the facility tracks residents' BMs and what was the protocol if there was no BM for 3 days. E41 stated that there was a print out from the computer that the nurses get and that if someone had not moved their bowels in 3 days then the protocol was started. She stated that the protocol included that MOM was administered and repeated if there was no BM, if the 2nd MOM was not effective then a Dulcolax suppository was administered and if that was not effective then a fleets enema would be given. E41 stated that the bowel protocol would be put on the prn (as needed ) part of the MAR whenever it was initiated.</p> <p>On 9/20/12 at 11:45 AM in an interview, E2 (DON) reviewed the BM Elimination Pattern from 2/12 through 9/12 for R27. E2 stated upon review, she realized that the resident had no BM's for multiple days. E2 stated that she looked at the printout for May and saw that R27's name was not on the sheet but should have been for having no BM for 3 or more days. E2 then stated that there were a few times a BM was noted for R27 on the 24 hour report but it was not entered into Care Tracker, the computerized system. E2 stated that she did not know why R27's name was not coming up on the report when she failed to have a BM in 3 days in order to initiate the bowel protocol. E2 acknowledged that the facility failed to monitor BM's for R27. E2 also confirmed that the resident had not been hospitalized since admission to the facility.</p>	F 309			

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F 309	Continued From page 24 The facility failed to monitor when R27 had no BMs for 3 or more days and failed to consistently implement the bowel protocol during 3/12 through 7/12. On 9/20/12, findings were confirmed by E2 as noted above.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, 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 closed record review and interview, it was determined that the facility failed to ensure that two (R10 and R89) out of 37 stage 2 sampled residents, who were incontinent of bladder received appropriate treatment and services to improve or maintain bladder function as was possible. The facility failed to complete a 3 day bladder flow sheet and bladder incontinence assessment as per facility policy and failed to determine if R10 and R89 were appropriate for retraining or not. Both R10 and R89 declined in urinary continence from their admissions to the facility on 2/20/12 and 5/31/12 respectively. Findings include:  The facility's policy and procedure, "Bladder	F 315	F315  1. R10 and R89 no longer reside at the facility.  2. All residents have the potential to be affected by this practice. An audit of all residents' bladder assessment will be conducted by DON or designee to identify any resident that is incontinent and a voiding diary will be completed to determine if the resident is eligible for retraining.  3. Licensed nurses will be educated regarding the identification of residents' incontinence status and initiating a voiding diary when appropriate. A weekly audit by the will be conducted by the DON or designee on all newly admitted residents, readmitted residents quarterly assessment of the Bladder Elimination assessment and Care Tracker report which identifies incontinent episodes to identify the need of a voiding diary. Any variances will be immediately corrected.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	11/6/12

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F 315	<p>Continued From page 25</p> <p>Elimination Assessment" developed on 1/1/01 and last revised on 6/30/06, included, "...3. The nurse will review the data from the Bladder Incontinence Assessment and 3-Day Bowel/Bladder Flow Sheet to determine if the resident is a candidate for a re-training program. If it is determined that the resident is an appropriate candidate for a retraining program, the resident will be referred to the Restorative Program. 4. If the resident is not a candidate for a re-training program (or refuses to participate in the program), care planning for the resident should take into account the individual findings of the assessments. 5. Re-assessment should occur with any significant change, annually or as deemed necessary..."</p> <p>1. R10 was admitted to facility on 2/20/12 with diagnoses of metastatic breast cancer and urinary tract infection (UTI) in the last 30 days, anxiety and depression. The admission Data Collection Tool, dated 2/20/12, had R10's bladder function checked as continent.</p> <p>R10's admission Minimum Data Set (MDS) assessment, dated 2/27/12 R10's functional status was coded as "1/1", supervision/set up help only in the areas of bed mobility, transfer, walk in room and corridor and dressing and was coded as "1/2", supervision/ 1 person physical assist in the areas of locomotion on and off of the unit and toilet use.</p> <p>R10 was discharged to the hospital on 3/23/12 and returned to the facility on 3/30/12 with diagnoses including UTI, pneumonia, pulmonary nodules with history of breast CA, anxiety and depression.</p>	F 315		

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F 315	<p>Continued From page 26</p> <p>A Bladder incontinence assessment, dated 3/30/12, checked the bladder continence scale as "complete control".</p> <p>The PPS Readmission MDS assessment, dated 4/6/12, coded urinary continence as "0" which indicated "always continent".</p> <p>Additionally, R10 was admitted to the hospital on 4/9/12 and returned to the facility on 4/14/12 with diagnoses including metastatic breast cancer, lumbar spine degenerative changes, generalized weakness, debility and with a history of UTI and pneumonia.</p> <p>A Bladder incontinence assessment, dated 4/14/12, checked the bladder continence scale as "complete control".</p> <p>Review of the facility's electronic documentation for bladder continence/incontinence for 4/17/2012 through 4/21/12 revealed R10 was incontinent of urine on the following dates: 4/17/12 during 3:30 PM - 11:30 PM shift; 4/20/12 during 11:30 PM - 7:30 AM and 7:30 AM - 3:30 PM shifts; 4/21/12 during 7:30 AM - 3:30 PM shift.</p> <p>The Significant change MDS, dated 4/21/12, for urinary continence was coded "1" which indicated that R10 was occasionally incontinent, less than 7 episodes of incontinence and the toileting program was coded "0", which indicated none. R10's functional status was coded as "3/3", extensive assistance/two + persons in the areas of bed mobility and transfer; as "3/2", extensive assistance/one person in the areas of locomotion on and off the unit, dressing and toilet use; as</p>	F 315			

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F 315	<p>Continued From page 27</p> <p>"2/2", limited assistance/one person in the areas of walk in room and corridor and hygiene.</p> <p>The Care Area Assessment (CAAs) Summary, dated 4/27/12, was triggered and checked for care plan decision in the area of urinary incontinence.</p> <p>Despite a decline in urinary continence, record review lacked evidence that an assessment of the change of continence was completed.</p> <p>On 9/21/12 at 11:57 AM in an interview, E14 (CNA) stated that R10 did have incontinence in April 2012. E14 stated that the resident was weak after pneumonia and other health issues and even had to use incontinent briefs for a couple of weeks. E14 stated the resident even used a bedpan but eventually did get stronger and did improve. E14 stated there that there wasn't a permanent nurse assigned to that end of the unit and two to three nurses would rotate the assignment. E14 stated that at times, the nurses helped with changing R10 and were aware of her incontinence.</p> <p>On 9/21/12 at 2:20 PM in an interview, E2 (DON) acknowledged that R10 was incontinent and triggered on the CAAs for urinary incontinence and was checked for care planning, however, the facility did not assess the resident, nor complete a 3 day diary and bladder incontinence assessment and failed to develop an individualized urinary incontinence care plan.</p> <p>The facility failed to thoroughly assess R10 when she became incontinent and determine what appropriate services R10 required to improve</p>	F 315		

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F 315	<p>Continued From page 28 bladder function.</p> <p>2. R89 was admitted to the facility on 5/31/12 with diagnoses that included pneumonia, dementia with behavioral disturbances, acute kidney failure, prostate cancer post brachytherapy (type of internal radiation therapy), colon cancer and C diff (Clostridium difficile-cause of antibiotic associated diarrhea).</p> <p>The closed record review revealed the facility's Data Collection Tool, dated 5/31/12 which stated that R89's decision making was severely impaired, that he was incontinent of bladder and was dependent for all activities of daily living (ADL), except for eating.</p> <p>An undated Bladder Incontinence Assessment was found incomplete and stated under Reassessment Notes "Due to residents cognitive deficits, not a candidate for bowel and bladder training at this time."</p> <p>The initial Minimum Data Set (MDS) assessment, dated 6/7/12 stated R89's cognition was severely impaired and that he required extensive assist of one person for transfers, dressing, toilet use and hygiene. This same MDS coded bladder status as a "2" or frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Although the initial MDS triggered the care area of urinary incontinence and was checked off to be addressed in care planning, the facility failed to develop a plan of care based on the resident's individualized, assessed needs for toileting in order to maintain as much bladder function as was possible. The facility did incorporate</p>	F 315		
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F 315	<p>Continued From page 29</p> <p>interventions to assist the resident to the toilet as needed and to provide incontinence as part of the potential for alteration in skin integrity care plan.</p> <p>Review of electronic CNA data sheets from 6/1/12 through 6/8/12 revealed that R89 had at least three (3) episodes of continent voiding.</p> <p>Review of R89's closed record lacked evidence that a 3 day voiding diary had been completed as per facility policy. The facility failed to complete a voiding diary and failed to thoroughly assess R89's bladder continence status.</p> <p>The 8/25/12 quarterly MDS stated that R89's bladder status was now coded as a "3" or always incontinent (no episodes of continent voiding). Review of the electronic CNA data from 8/19/12 through 8/26/12 revealed that R89 had no documented episodes of continent voiding.</p> <p>In an interview with E14 (CNA) on 9/21/12 at 11:10 AM, E14 stated that she remembered R89 and that he was able to complete tasks when cued and supervised. E14 stated that R89 did use the bathroom when he was taken and she usually tried to toilet him after breakfast and lunch. E14 said that if you asked R89 if he needed to use the bathroom he would always say "no," but that she would seat him on the toilet and at times he would be dry and voided and at other times he would already be wet.</p> <p>During an interview with E16 (CNA) on 9/21/12 at 11:35 AM, E16 was asked how she would document the bladder status of a resident who was both continent and incontinent on her shift. E16 stated that she would enter it as incontinent.</p>	F 315			

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F 315

Continued From page 30

E15 (CNA) was interviewed on 9/21/12 at 11:45 AM. E15 stated that R89 was able to stand and pivot by holding onto the grab bar in the bathroom. She stated that she toileted him usually after meals, but that he never asked to use the bathroom. E15 also stated that at times he would be continent and void when toileted. When asked how she would input the data for bladder status for a resident who was both continent and incontinent during her shift, she stated that she enter it as incontinent.

The facility failed to provide R89 with appropriate treatment and services to restore as much normal bladder function as possible. R89 was admitted to the facility with some continence of bladder. The facility failed to complete a thorough assessment (e.g. voiding diary) and failed to develop a toileting plan in order to attempt to improve and/or prevent decline in bladder function.

On 9/21/12 at 12:20 PM findings were reviewed with and acknowledged by E1 (Administrator), E2 (DON) and E4 (Corporate Nurse) during an interview.

F 315

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/21/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHIPLEY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2723 SHIPLEY ROAD</b> <b>WILMINGTON, DE 19810</b>	
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F 323	Continued From page 31  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible for one (R28) out of 37 stage 2 sampled residents. The facility failed to maintain the proper function of a side rail which was very loose and posed a potential accident hazard for R28. Additionally, there were multiple observations of the 500 Hall tub room door left ajar, unlocked and accessible to residents. Findings include:  1. R28 was readmitted to the facility on 8/14/12. R28 had a history of falls and fractures. Her last documented fall with a right 7th rib fracture occurred on July 24, 2012.  R28's Significant Change MDS (Minimum Data Set) assessment, dated 8/20/12, revealed that R28 was assessed as requiring extensive assistance with two person assist for bed mobility and transfer. R28's clinical record revealed that she was assessed as a high risk for falls and was care planned for falls. Review of the September 2012 Physician's Order Sheet included a physician's order, dated 8/14/12 for "Fall precautions."  On 9/11/12 at 11:28 AM, R28 was observed in bed with the left 1/2 side rail up. This side rail was observed to be very wobbly and loose.  On 9/11/12 at 11:30 AM, findings were confirmed with E17 (CNA), who stated she would inform maintenance.	F 323	F323  1. R28 no longer resides at the facility. The side rail was repaired when E17 notified the maintenance staff who immediately responded on 9/11/2012 and tightened the side rail for safety. Education was provided to E17 on 9/14/2012 regarding the PM (Preventive Maintenance) work order system for proper documentation of safety repairs. The 500 hallway tub room door's threshold was repaired and the door closure was adjusted by maintenance staff on 9/18/2012 and door remains properly secure and safe.  2. All residents have the potential to be affected by this same practice. An audit of all beds' side rail was conducted by the Director of Maintenance on 9/11/2012 with no other side rails identified as loose or needing repair. An audit of all key pad locked doors was conducted by the Director of Maintenance on 9/18/2012 with all doors found working properly.	11/6/12

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F 323	<p>Continued From page 32</p> <p>During an interview on 9/19/12 at 3:15 PM, E8 (Director of Maintenance) denied having any routine maintenance check for resident side rails. E8 stated that he finds out about side rail issues when staff fill out a PM (Preventive Maintenance) request. He denied having a system in place for regular maintenance checks on side rails and stated, "No...but I guess we should." E8 stated that they relied on someone such as the nursing staff, to inform maintenance of any issues. He provided copies of PM requests done in August and September. However, there was no PM request for R28's side rail. He stated that he would have to investigate this because he should still have a work order to show the work was done.</p> <p>On 9/21/12 at 1:35 PM, E8 returned with a copy of the completed work order. He stated that he had to write one up.</p> <p>2. The tub room on the 500 hall, which had a key pad lock on the door was observed with the door ajar and accessible to residents on the following dates: 9/11/12 at 8:10 AM, 9/11/12 at 9:35 AM, 9/14/12 at 8:52 AM and 9/18/12 at 11 AM.</p> <p>E7 (nurse supervisor) confirmed that the door should remain closed and locked during interviews immediately after the observations on 9/11/12 at 8:10 AM, 9/11/12 at 9:35 AM, and 9/18/12 at 11 AM. E10 (nurse) confirmed the same on 9/14/12 at 8:52 AM.</p>	F 323	<p>3. Education will be provided to all staff regarding the PM (Preventative Maintenance) work order system to properly notify maintenance and document identified needed repairs to ensure safety.</p> <p>An audit will be conducted monthly by the Director of Maintenance or designee on all beds' side rails to ensure they are properly secure and in safe working order. Variances will be immediately corrected.</p> <p>An audit will be conducted weekly by the Director of Maintenance or designee of all key pad locked doors and door swing to ensure that they close and secure properly. Variances will be immediately corrected.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>	
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of</p>	F 332		

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F 332	<p>Continued From page 33 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined that the facility failed to ensure it was free of medication errors of five percent or greater. Three medication errors were identified during the medication pass for one resident (R2) that included the administration of the anticonvulsants Lamictal and Valproic Acid, and the antihypertensive medication Lisinopril . Findings include:</p> <p>The facility policy "Administration of Medication Via Enteral Feeding Tubes" states "...7b. Tablets: If liquid form of medication is not available, crush tablet to fine powder and mix thoroughly with 30 cc of room temperature water in a medicine cup...9. Fill 60cc catheter tipped syringe with liquid or crushed and diluted medication..."</p> <p>On 9/18/12 at 9:05 AM, E11 was observed preparing and administering medications to R2 via a feeding tube. A Lamictal 200 mg tablet and a Lisinopril 2.5 mg tablet were crushed separately and placed in individual medication cups. The Valproic Acid oral solution 5 ml (250mg/5ml) was poured into a third medication cup.</p> <p>E11 correctly checked placement of the feeding tube and flushed the tube prior to administration of the medications. E11 did not add water to any of the two medications that had been crushed. E11 poured water into the piston syringe (attached to the feeding tube to deliver the</p>	F 332	<p>F332</p> <ol style="list-style-type: none"> <li>1. R2 remains clinically stable. E11 received education on 9/18/2012 to ensure that medication administration does not affect the physician ordered dosage.</li> <li>2. All residents who receive crushed medications via feeding tube have the potential to be affected by this practice. One other resident receives crushed medication via feeding tube and an audit was conducted by the DON on 9/18/2012 which had no variance in practice, specifically, no variance that affected the dosage.</li> <li>3. Education will be provided to all licensed staff regarding medication administration of crush medication via feeding tube to ensure that administration practice is compliant to achieve proper medication dosage. An audit will be conducted on all licensed staffs' medication administration for crushed medication administered via feeding tube to ensure compliance with physician ordered dosage.</li> <li>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</li> </ol>	11/6/12

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F 332	Continued From page 34 medications) and poured each of the three medications separately into the syringe, flushing in between. After administration of the medications, E11 administered an additional ordered amount of fluid. Observation of the medication cups revealed that there was residual medication left at the bottom of all three cups. E11 did not add water to each of the medication cups in order to ensure that the full dosage was administered. E11 was questioned immediately after as to why she did not add water to the medication cups and she stated that she was trying to watch the amount of fluid being given to R2. Review of R2's physician orders revealed that he was not on a fluid restriction.  During an interview on 9/21/12 at 11:45 AM with E2 (DON), she acknowledged that E11 should have added water to the medication cups to ensure correct dosage was administered.	F 332		
F 371 SS=E	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 made in the dietary department, facility documentation review, and	F 371		

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F 371	Continued From page 35 staff interviews, it was determined that the facility failed to prepare, serve, and distribute food under sanitary conditions to prevent the outbreak of food borne illness. Food stored inside freezers and refrigerators was unlabelled, undated and one pan was uncovered. Additionally, a refrigerator thermometer was in disrepair, dietary staff health forms for two of four employees (E24 and E25) were unsigned and lacked review by appropriate management staff, and debris was observed on the floor in the kitchen area. Findings include:  1. Observations made on the initial tour of the kitchen on 9/11/12 at approximately 8:00 AM with E21 (Dietary Aide) revealed the food items stored in the refrigerators and freezers were undated after the food was opened or improperly stored as follows: 1a. Observation of the food in the Traulsen Reach-in Refrigerator in the kitchen revealed: - Two trays with at least 15 pudding cups were unlabelled and had no date when the food was prepped; - An opened large bottle/jar of seafood cocktail sauce lacked the date when bottle was opened; - An opened large container storing a carrot and raisin salad had no date as to when the container was opened; - An opened container (with a lid) of Concord grape jelly was undated; - An opened container of fruit punch was unlabelled and undated; - A tray with full glasses of milk and juice (not in original containers) lacked the date when the food was prepped and was unlabelled.  On 9/11/12 at approximately 8:30 AM, E21 stated	F 371	F371  1. No residents are identified as being affected by the practice. 1a. Identified items in the Traulsen Reach-in Refrigerator that were unlabeled, undated, and/or open were immediately discarded. 1b. Identified items in the Walk-in Freezer (outside) that were unlabeled, undated, open and/or did not have expiration dates were immediately discarded. 1c. Identified items in the Walk-in Refrigerator (inside) that were open without date, unlabeled, undated, and/or thawed without identifying label were immediately discarded. E21, E22, and E23 received education regarding cover/label/date; expiration dates on items when removed from original packaging; sanitation; thermometer calibration; and proper holding of cold foods to maintain safe holding temperatures not to exceed 40 degrees F. 2. New thermometers were immediately obtained from the Food Services Director inventory to ensure accuracy of measurement. 3. The 3-compartment sink was immediately cleaned of visible debris. The contracted vendor for pest control (Western) was immediately notified and inspected the area the evening of 9/11/2012 with a documented report of no pests in the pantry or specifically, in the area identified with the sighting. The drinking glasses were sanitized.	11/0/12

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F 371	Continued From page 36 that once containers were opened they were supposed to be dated and that food prepped needed to be dated. E21 stated that "someone forgot to date them" and he confirmed this finding.  1b. Inspection of the walk-in-freezer, located outside of the kitchen, on 9/11/12 at approximately 8:45 AM with E21 (Dietary Aide), revealed the following: - Five (5) beef roast (wrapped in original plastic) stored in a red crate in the walk-in-freezer lacked a date when they were delivered to the facility. The roasts had no use-by dates, or expiration dates; - Twelve (12) frozen mixed vegetable bags, such as frozen cut wax, carrots, stored in a crate inside the freezer were undated. The vegetable bags lacked expiration dates or use-by-dates; - A pan full of a cooked, cheese dish was not covered, unlabelled and undated. E21 on 9/11/12 at 8:45 AM stated that he could not identify the cheese dish and confirmed the finding.  1c. Inspection of the walk-in refrigerator inside the kitchen on 9/11/12 at approximately 8:00 AM with E21 (Dietary staff) revealed the following: - One (1) opened jug of milk lacked a date when first used or opened; - Two (2) cranberry/grape juice jugs lacked a date and were unlabelled; - An opened container of heavy whipping cream lacked the date when the container was opened; - Two (2) opened bars of cheddar cheese taken out of their original packaging lacked a date of opening; - One (1) large unopened and one opened scrapple bar observed not in the original	F 371	4. E24 and E25 have new forms with correct signatures which have been reviewed by the Food Service Director and are deemed free of foodborne illnesses that would prevent them from working with food.  2. All residents have the potential to be affected by this practice. All refrigeration and freezer storage areas were immediately audited by Food Service Director on 9/11/2012 to ensure compliance with standards (cover/label/date/expiration date when out of original package) with no other variances identified. The Food Service Director audited the calibration of the thermometers used throughout all food areas and found no other faulty thermometers. The Food Service Director initiated an audited conducted before and after each service of 3-compartment sink and no there were no sanitation variances with no visible debris. The Food Service Director initiated a daily audit for surveillance of pests and no pests were sighted. This was confirmed by the documented report from the facility's pest control vendor (Western). An audit of all food service staffs' "Conditional Employee & Food Employee Interview" forms will be conducted by the Food Service Director for compliance.	

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F 371	<p>Continued From page 37</p> <p>packaging were unlabelled and lacked a date when the one package was opened or when both bars were delivered. They lacked a label and a use-by or expiration date;</p> <p>- Four (4) uncooked beef tubes that were thawed-out inside the refrigerator lacked a date when the tubes were thawed out or taken out from the freezer.</p> <p>Review of a facility policy entitled, "Food Safety in Receiving and Storage" under "Dry Storage Guidelines" documented that "open packages will be resealed tightly and dated with date open to prevent contamination and dated with opened date". The Policy also documented under "General Food Storage Guidelines" that "food that was repackaged... the container needed to be labeled with name of the contents and dated with the date it was transferred to the new container. The "Receiving Guidelines" section of the Policy documented that "expiration dates and use-by-dates will be checked to assure the dates are within acceptable parameters". However, the Policy lacked the acceptable parameters.</p> <p>2. Review of the facility policy entitled "Safe Food Temperatures" revealed that "cold food will be held at 41F degrees or lower during meal service (on the tray line)".</p> <p>Observations of the first floor pantry/dining room kitchenette on 9/11/12 at 8:35 AM revealed a tray with eight (8) yogurt (4-oz containers), and a tray with milk glasses that were stored undated in an unrefrigerated cart, or table respectively inside the pantry area. E23 (Cook) was observed serving breakfast from the steam table in the pantry room and E22 (Dietary Aide) was placing</p>	F 371	<p>3. Education will be provided to all Food Service staff regarding standards as reflected in facility policies (FB-6048 Safe Food Temperatures; FB-6113 Pest Control; FB-6108 Food Safety in Receiving and Storage; FD-AL/IL-504.F2 Guidelines for Checking Food Temps) and the "Conditional Employee &amp; Food Employee Interview". Specifically, the education provided will include cover/label/date; expiration dating when food out of original package; safe food temperatures and calibration of thermometers; sanitation of food service areas (including 3-compartment sinks) and pest surveillance and reporting. Education will be provided by the NHA or designee to the Food Service Director and HR Director regarding the "Conditional Employee &amp; Food Employee Interview" to ensure compliance.</p>	

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F 371	<p>Continued From page 38</p> <p>milk glasses, or yogurt containers, on the food trays delivered to residents in the dining room.</p> <p>Observation of the facility thermometer used to test the yogurt and milk on 9/11/12 at 8:55 AM with E23 indicated the milk and yogurt was 40 degrees Fahrenheit and the thermometer would not move from that number/reading. The surveyor's thermometer registered a temperature of 59 degrees Fahrenheit. Using an ice/water mixture, the thermometers (facility and surveyors) were immersed in the mixture and the facility thermometer measured 20 degrees F, when the water was above 32 degrees F. The two thermometers were off by 1.5-2 degrees Fahrenheit when a new thermometer was tested with the ice/water mixture. The food was retested with the new facility thermometer and the yogurt was 61 degrees F and the milk was 52 degrees F, above the safe storage temperature for milk, or milk products, required to be maintained (which is below 41 degrees F).</p> <p>In an interview with E22 (Dietary Aide) on 9/11/12 at approximately 8:38 AM, she stated that she placed the trays on the table or cart, as she had no space in the ice cream freezer or the reach-in refrigerator to store them which were observed with other trays of beverages.</p> <p>On 9/11/12 at 8:35 AM, E22 stated that she prepped the milk and yogurt trays this morning in the kitchen and brought down to the pantry area at around 7:35 AM.</p> <p>In an interview with E23 (Cook) and E22 on 9/11/12 at 8:55 AM, E23 confirmed the thermometer he was using was not reading the</p>	F 371	<p>A bi- weekly compliance audit will be conducted by Food Services Director or designee regarding:</p> <ol style="list-style-type: none"> <li>1. All refrigeration and freezer areas for cover/label/date; expiration dating when out of original package</li> <li>2. Thermometers for proper calibration</li> <li>3. Sanitation in food service areas</li> <li>4. Pest surveillance</li> <li>5. "Conditional Employee &amp; Food Employee Interview" forms</li> </ol> <p>Any variances will be immediately corrected and documented on the monthly CQI report.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>	

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F 371	<p>Continued From page 39</p> <p>correct temperature. E22 stated that they try to keep the trays of milk and yogurt inside the ice cream freezer until they serve it, but they do not have space for all of the trays all the time.</p> <p>In an interview with E9 (Food Service Director) on 9/11/12 at 11:30 AM, he confirmed they do not have enough space to store trays of prepped milk and yogurt in the pantry room.</p> <p>Observation of the pantry area on 9/21/12 at 8:43 AM revealed two yogurt containers unrefrigerated on a tray in a cart in the pantry area while staff was serving breakfast. Glasses of milk in a tray were observed inside the ice machine freezer. The staff was almost done with breakfast.</p> <p>3. Observations of the kitchen area on 9/11/12 at approximately 8:15 AM with E21(Dietary Aide) revealed debris on the corner areas of the 3-compartment sink and in the food supply room. A roach was observed walking around clean drinking glasses in a cart located near the 3-compartment sink in the kitchen.</p> <p>In an interview with E21 on 9/11/12 at approximately 8:15 AM, he stated they have never seen roaches in the kitchen before. Review of pest control logs revealed that they called the pest control vendor to address this pest seen in the kitchen.</p> <p>4. Review of facility staff health forms revealed that E24 (dietary staff) had not signed a "Conditional Employee and Food Employee Interview" health form indicating that they were free of any food-borne illness which would prevent them from working in the kitchen. Also,</p>	F 371		

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F 371	Continued From page 40 review of the health form documentation for E25 (Dietary staff) revealed that E25 had signed the form. Additionally, the form was not reviewed by appropriate food service personnel to determine E25 could work in the kitchen.  In an interview with E26 (Human Resource Manager) on 9/19/12 at 9:00 AM, she stated that she was responsible for completing and reviewing the kitchen employee health forms and that she had missed those two. She stated she had no training on the Food Codes.  In an interview with E8 (Food Service Director) on 9/19/12 at 9:30 AM, he confirmed he did not review the staff food service health forms. He stated the forms were done by HR staff (E26) and that he interviewed dietary staff prior to hire but was not involved in the review of the health forms.  The facility failed to review the health condition of new dietary employees to determine if E24 and E25 were free of foodborne illnesses that would prevent them from working with food. The staff reviewing the forms lacked knowledge of the Food Codes.	F 371	F372  1. No residents are identified as being affected by the practice.  2. The large garbage barrel was immediately removed and a replacement lid ordered, received, and placed into service. The Food Service Director conducted an immediate audit of all other garbage barrels within the food services areas and no variances were identified.  3. Education will be provided with all food service staff regarding the standards and facility policy for garbage containers to be leak-proof, nonabsorbent, and with close-fitting covers. Additionally, the food service staff will be educated regarding variance reporting to the Food Service Director. A bi-weekly audit will be conducted by the Food Service Director of designee of all garbage containers to ensure that they are compliant with standards and policy (leak-proof, nonabsorbent, and with close-fitting covers). Variances will be immediately corrected and documented on the monthly CQI report.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	11/6/12
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation of the kitchen area and staff interview, it was determined that the facility	F 372		

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F 372	Continued From page 41 failed to keep a large barrel, storing garbage and refuse, covered to prevent pest harborage. Findings include:  Observation of the kitchen area on 9/11/12 at 8:10 AM with E21 (Dietary Aide) revealed a large refuse/food garbage barrel with a lid on top. The lid was designed with an opening on both side that remained open. The barrel was not in use at the time. The barrel was observed to contain garbage/food refuse and needed to be covered to prevent harborage of pests.  In an interview with E21 on 9/11/12 at approximately 8:10 AM, he confirmed this finding.  In an interview with E9 (Food Service Director) on 9/11/12 at approximately 11:30 AM, he revealed the lid would stay closed if the springs inside the unit were working correctly. E9 stated that the springs were not working correctly and the kitchen staff failed to alert him of the problem.  Review of a facility procedure entitled "Pest Control" revealed that "garbage containers are leak proof, nonabsorbent and with close-fitting covers".	F 372		
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.	F 431	F431 1. All medications stored in the refrigerator for R1, R20, R27, R60, R66, R75, R90, R96, R104, R120, R158, and R164 were destroyed on 9/20/2012. The refrigerator was replaced within 2 hours of identified temperature issue.	11/6/12

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F 431	<p>Continued From page 42</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations on 9/20/12 at 7:27AM and staff interview, it was determined that the facility failed to ensure that all drugs and biologicals were stored under appropriate environmental controls. For 13 out of 62 residents currently in the facility, the facility failed to store medications under proper refrigeration temperature. Additionally, the facility failed to ensure proper refrigerator temperatures for four house stock medications, and failed to</p>	F 431	<p>2. An audit was conducted by DON on 9/20/2012 of all medications located in the refrigerator which were subsequently destroyed and replaced.</p> <p>3. RN Supervisors will receive education regarding temperature monitoring and daily documentation of medication refrigerator temperatures to ensure they are within 38-46 degrees F, according to policy. Variances will be immediately reported and corrected. A weekly audit will be conducted by DON or designee of the medication refrigerator temperature log to ensure that the log is documented correctly and that the temperatures remain within the stated range of 38-46 degrees F, according to policy. Variances will be immediately corrected. A weekly audit by the Director of Maintenance or designee will be conducted regarding the accumulation of ice inside the refrigerator to ensure preventative measures to maintain policy stated temperature range of 38-46 degrees F. Variances will be immediately corrected.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>	

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F 431	<p>Continued From page 43</p> <p>consistently monitor the medication refrigerator for proper temperatures. Findings include:</p> <p>1. Observation of the medication refrigerator on 9/20/12 at 7:27 AM with E7 (RN Supervisor) revealed a reading of 60 degrees Fahrenheit on the thermometer kept inside the refrigerator. Heavy frost and ice was observed inside the refrigerator freezer area.</p> <p>a. Resident specific medications, labeled as requiring refrigeration for R1, R20, R27, R60, R66, R75, R90, R96, R104, R120, R158, and R164 were stored inside this refrigerator.</p> <p>E7 stated on 9/20/12 at 2:09 PM that the label indicating to refrigerate Acephen (acetaminophen) suppositories for R2 had come off and did not have to be refrigerated.</p> <p>b. The following house stock medications, labelled as requiring refrigeration were stored in the medication refrigerator:</p> <ul style="list-style-type: none"> <li>- Two (2) Tubersol bottles (50 test units) for tuberculin testing.</li> <li>- Three (3) boxes of Humulin R insulin.</li> <li>- One (1) box of Novolog insulin.</li> <li>- One (1) Lantus 100ml/vial.</li> </ul> <p>The surveyor's thermometer was then used to test the temperature of the refrigerator. The thermometer was placed inside the refrigerator for 30 minutes when the refrigerator was not being opened and closed. After the 30 minutes, the thermometer indicated a temperature of 59.5 degrees Fahrenheit.</p> <p>In an interview with E7 on 9/20/12 at 8:15 AM,</p>	F 431		
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F 431	<p>Continued From page 44</p> <p>she confirmed this finding. E7 stated that the 11x7 shift took measurements when the refrigerator was not open as much as during the first shift. She stated that in the mornings, the refrigerator was opened all the time and with the frost, they are unable to get the proper temperature reading right away.</p> <p>In an interview with E9 (Maintenance Director) with E7 present on 9/20/12 at 8:30 AM, he revealed that there was a problem with the refrigerator, he knew why it was not working, that the refrigerator needed to be thawed out, and the thick crust of ice in the freezer area was the problem. E9 indicated that he would have the refrigerator replaced.</p> <p>In an interview with E7 on 9/20/12 at 9:35 AM, she stated that the medication refrigerator had been replaced.</p> <p>On 9/20/12 at 2:09 PM, E7 provided the surveyor a document from the pharmacy provider which stated that the Bisacodyl (Bisac Evac) and acetaminophen (Acephen) did not have to be refrigerated, but that they could be refrigerated. E7 stated that after talking to the pharmacy, they were planning to discard and replace all the medications found in the refrigerator that morning.</p> <p>2. Facility failed to consistently monitor the temperature of the medication refrigerator.</p> <p>Review of refrigerator temperature logs from April 2012 through September 2012 revealed undocumented temperatures for 71 of 173 days.</p>	F 431			

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F 431	Continued From page 45 In an interview with E7 (RN Supervisor) on 9/20/12 at 7:45 AM, she confirmed this finding. She stated that the temperatures were recorded by the 11 PM-7 AM shift and usually they were PRNs (indicating they did not work full time). She stated that they were working on this.  Review of facility Policy entitled "Medication Management Guidelines" documented under Section "Drug Storage" and "Monitor Storage Temperatures" to "Check refrigerator temperatures daily to ensure the temperature range is maintained. Store items requiring refrigeration at 38-46 degrees F".	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441  1. No residents indicated as affected by this practice. E20, E35, E36, E37, E38, E39, and E40 have received their TB test with negative test results documented on the "Tuberculosis Individual Record-Employee" form, appropriately signed by a nurse. Compliance for timing prior to hire cannot be retroactively achieved.  2. An audit will be conducted by the HR Director or designee of all newly hired staff within the past 12 months (and still employed) for compliance to policy. Variances will be immediately corrected.	11/6/12

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F 441	<p>Continued From page 46</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to provide a safe, sanitary and comfortable environment that helped prevent the spread of infections, with regards to the processing and handling of soiled linens. The facility failed to monitor the chemical concentrations required to destroy microorganisms in the washer when the wash water temperatures were below 160 degrees Fahrenheit and linens heavily soiled with stool were being added to the washer. Additionally, the facility failed to monitor that seven (E20, E35, E36, E37, E38, E39 and E40) of 15 staff had tuberculin testing completed before starting employment. Findings include:</p> <p>1. The facility's Infection Control Policy regarding Laundry, entitled "Soiled Linen Handling" was reviewed. The policy failed to address the</p>	F 441	<p>3a. The water temperature for the washers will be maintained at 160 degrees F. The facility main boiler thermostat has been replaced so that temperature readings are consistent during weekly PM (Preventative Maintenance) audits. Any variance to the defined 160 degree F standard will be immediately corrected. Effective 9/20/2012, the E30 (Chemical Vendor Staff) reports now document the sanitizer concentration levels to account for heavily soiled (with stool) linens. Education will be provided to the Maintenance staff regarding the temperature log and reporting of variances when temperature is not compliant with 160 degrees F. A monthly audit will be conducted by the Director of Maintenance or designee of the washing machine temperature log and the Chemical Vendor's report for sanitizer concentration levels to ensure compliance. Variance will be immediately corrected.</p> <p>3b. Education was provided to Director of Staff Development and HR Director on 10/12/2012 regarding the employment new hire process for tuberculin testing compliance. An audit will be conducted monthly by the DON or designee of the "Tuberculosis Individual Record-Employee" for all newly hired staff to ensure compliance. Policy variances will be immediately corrected.</p>		

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F 441	<p>Continued From page 47 process of the washing of soiled linens.</p> <p>Observations on 9/18/12 at 10:30 AM of the laundry's two (of three) large washers with E27 (Laundry Staff) and E28 (Laundry Staff) revealed the temperature of the wash water to be 53 degrees and 102 degrees Fahrenheit respectively, below the recommended State regulation minimum temperature of 160 degrees F.</p> <p>In an interview with E27 and E28 on 9/18/12 at 10:30 AM, they revealed that they did not monitor water temperatures and they directed the surveyor to talk to the maintenance staff.</p> <p>Observations on 9/19/12 at 2:30 PM with E8 (Maintenance Director) and E29 (Maintenance staff) of the facility surface thermometer (used to test the temperature of the pipe above the hot water heater) in the mechanical room revealed the temperature to be 131 degrees F.</p> <p>The water gauge located in the mechanical room could not be read. In an interview with E8 on 9/19/12 at 2:30 PM, he revealed that the water temperatures at the washers were below 160 degrees F and the highest was 153 degrees F during the summer times. E29 stated that the water temperature reading he took for the laundry was done at the washer with the faulty reading of 53 degrees F. In an interview with E8 on 9/20/12 at approximately 2:40 PM, the surveyor requested the chemical dispensing system vendor reports to determine if the proper concentration of the chemical was obtained during the last year since the facility was using a low temperature washer system.</p>	F 441	4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	

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F 441	<p>Continued From page 48</p> <p>Review of the logs (entitled "Water Temps: Test and log hot water temperatures in patient, dietary, and laundry areas") revealed that the washer hot water temperature had varied from 109 degrees F to 153 degrees F from September 2011 to September 2012 and did not reach 160 degrees F.</p> <p>Review of the chemical vendor "Routine Preventative Maintenance Service Detail Report - Laundry" from January to August 2012 revealed the reports lacked documented evidence of the concentration levels of chlorine bleach, or the chemical vendor hydrogen peroxide/ peroxyacetic acid sanitizer, in the wash but indicated the wash water temperature varied from 162-163 degrees F. In an interview with E8 and E30 (Chemical Vendor Staff) on 9/19/12 at 2:45 PM, E8 confirmed he never measured water temperatures above 153 degrees Fahrenheit and needed the chemical to do the sanitizing. E30 confirmed that he lacked the documentation of the sanitizer concentration in his reports and could start documenting this. E8 and E30 confirmed they lacked complete vendor reports that would indicate the concentration of the chemical in the wash</p> <p>Review of the vendor chemical wash sanitizing agent specifications revealed that the chemical provided sanitation against staphylococcus aureus, klebsiela pneumoniae, pseudomonas aeruginosa, and MRSA only. In an interview with E30 with E8 on 9/20/12 at 10:50 AM, E30 indicated that he could only place the sanitizing agent amount to be dispensed from their chemical system and could not add a concentration in the report.</p>	F 441		
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F 441	Continued From page 49  In an interview with E8 on 9/21/12 at 12:05 PM, he indicated that he was making changes to the laundry hot water system to obtain 165 degrees Fahrenheit at all times.  Facility failed to ensure that proper concentrations of the non-chlorine sanitizing chemical were dispensed and monitored when laundering soiled linen to prevent the spread of infections. 2. The facility failed to ensure that seven (E20, E35, E36, E37, E38, E39 and E40) out of 15 sampled staff had received their tuberculin test prior to hire, and had the results read and dated. Review of documentation revealed the following: a. E35 (hired 8/28/12) lacked documented evidence that the tuberculin skin test was provided. b. E36 (hired 5/1/12) lacked documented evidence that the tuberculin skin test was provided. c. E37 (hired 7/5/12) was given the tuberculin skin test, but documentation lacked evidence of the test result. Although the document was signed by the nurse, the result of the test was left blank. d. E38 (hired 7/30/12) was given the tuberculin skin test, but documentation lacked evidence of the test result. Although the document was signed by the nurse, the result of the test was left blank. e. E39 (hired 7/30/12) documented the TB skin test result for the staff, the nurse signature, yet result lacked the date in which the result was read. f. E20 (hired on 3/27/12) documented the TB skin test result for the staff, the nurse signature, yet result lacked the date in which the result was read.	F 441		

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F 441	<p>Continued From page 50</p> <p>g. E40 (hired 7/17/12) received the first TB test on 6/29/12 yet the test result was blank.</p> <p>In an interview with E26 (HR Manager) on 9/20/12 at approximately 2:40 PM, she confirmed this finding. In an interview with E2 (DON) on 9/20/12, she confirmed the findings.</p> <p>Review of facility policy entitled "Evaluation of Individuals with Positive TB Test Results" documented that "to rule out the presence of active TB, the facility provides timely evaluation". The policy entitled "Administering TB Skin Tests", "Documentation", documented to "document the absence of induration as 0, or the size of induration in mm". The Policy entitled "Interpreting TB Skin Tests - Documentation Requirements" documented that "Record all new hire and volunteer PPD test results on ..."</p> <p>3. An observation in the soiled area of the laundry on 9/21/12 at 11:05 AM with E28 (Laundry Staff) revealed a washable heavily soiled incontinent blue underpad with two formed pieces of BM (ranging about 2 to 4 inches in size) when staff was sorting the laundry in a melt away bag.</p> <p>In an interview with E28 (Laundry Staff) on 9/21/12 at approximately 11:10 AM, she stated she received soiled linen that usually had formed stool on it, and she had to place these linens with the stool inside a melt away bag (from a regular plastic bag in the carts), and placed the melt away bag inside the washers (that way) with other soiled linen. She indicated she had brought this concern up to management. In an interview with E7 (RN Supervisor) on 9/21/12 at 11:12 AM, she confirmed that the concern had been brought up</p>	F 441		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/21/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHIPLEY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2723 SHIPLEY ROAD WILMINGTON, DE 19810</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 441	<p>Continued From page 51</p> <p>to her and she followed up with an in-service to staff.</p> <p>Review of the in-service staff signed-up sheets entitled "Proper Handling of Soiled Utility, and Soiled Laundry" indicated that the dates of the in-service was from 2/9/12 to 2/11/12 and that 31 facility staffs were in-serviced.</p> <p>A copy of a policy entitled "Soiled Linen Handling", dated 1/1/01 was provided to the surveyor. Review of this Policy indicated that staff should "remove soiled bed linen in a manner to prevent excessive airing of linen. ...you may also place linen in pillowcase to carry to soiled hamper ...rinse non-disposal adult briefs in commode or hopper to remove excessive feces before putting in soiled linen hamper. Wear gloves if stool, urine, blood, or body fluids are present..."</p> <p>In an interview with other laundry staff (E31, E32, E33, E34) on 9/21/12 at 12:00 PM, they confirmed that they continued to receive heavily soiled laundry that contained large amounts of stool since the in-service.</p> <p>In an interview with E7 (RN Supervisor) on 9/21/12 at 1:20 PM, she stated that their ADLs procedures did not address soiled linens specifically. She stated they were using the 1/1/1 procedure on soiled linen that did not address specifically the handling of the incontinent blue underpads.</p> <p>In an interview with E30 (Washer Chemical Vendor) on 9/21/12 at 1:45 PM, he was not aware of a setting for handling extra stool in the wash and indicated that extra steps could be added to</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  SHIPLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810	
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F 441	Continued From page 52 the wash cycle, such as additional flushes to handle the solid stool in the washers.  In an interview with E4 (Corporate Nurse) on 9/21/12 at 2:25 PM, she indicated she was unaware that they were not documenting chemicals in the wash, and that they had other issues with the water system for the washers.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, the facility failed to provide or obtain laboratory services to meet the needs of one (R85) out of 37 stage 2 sampled residents. Findings include:  R85's had a physician's order, dated 7/17/12 for a CMP (Complete Metabolic Panel-laboratory blood test) to drawn on the week of 8/6/12.  R85's August 2012 MAR (Medication Administration Record) revealed that the CMP order was incorrectly transcribed as "BMP" (Basic Metabolic Panel).  Review of R85's clinical record revealed that a BMP had been completed on 8/6/12, instead of the CMP as ordered.  During an interview on 9/19/12 at 10:25 AM, E7	F 502	F502  1. R85's physician notified of incorrect transcription of BMP and the physician wanted no further action. R85 remains clinically stable with no affect from the practice.  2. An audit has been conducted by DON or designee of all residents' physician ordered laboratory services for the preceding 3 months to identify and immediately correct any variance from stated physician orders.  3. All licensed nursing staff will receive education regarding the transcription of laboratory services orders. The DON or designee will conduct random month audits (10% of total resident population) of all new physician orders for laboratory services to ensure proper transcription by licensed staff. Variances will be immediately documented and corrected.  4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.	11/2/12

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

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F 502	Continued From page 53 (nurse supervisor) checked the August 2012 MAR and the lab book. E7 confirmed that the CMP had not been done and stated, "You're right. It wasn't done." E7 stated that she felt this was due to the transcription error.	F 502		
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3201 3201.1.0 3201.1.2	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from September 11, 2012 through September 21, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 62. The Stage 2 sample totaled thirty seven (37) residents which included review of three (3) closed records.</p> <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> <p><b>This requirement is not met as evidenced by:</b></p>	<p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F156 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F166 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F241 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F246 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F253 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F278 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F279 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F280 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F309 11/6/2012</p>

Provider's Signature Wendy V. Neenan, NHA Title EXECUTIVE DIRECTOR Date 10/17/12



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<p><b>3201.7.5</b></p>	<p>Cross refer to the CMS 2567-L survey report date completed 9/21/12, F156, F166, F241, F246, F253, F278, F279, F280, F309, F315, F323, F332, F371, F372, F431, F441 and F502.</p> <p><b>Kitchen and Food Storage Areas. Facilities shall comply with the 2011 Delaware Food Code.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p><b>Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections: 2-201.11, 3-302.12, 3-501.16, 3-501-17, 3-602.11, 4-502.11, 5-501.113, and 6-501.114 of the State of Delaware Food Code. Findings include:</b></p> <p><b>2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.</b> <b>(A) The PERMIT HOLDER shall require FOOD EMPLOYEES and CONDITIONAL EMPLOYEES to report to the PERSON IN CHARGE information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report the information in a manner that allows the PERSON IN CHARGE to reduce the RISK of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE: reportable symptoms (1) Has any of the following symptoms:</b> <b>(a) Vomiting,</b></p>	<p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F315 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F323 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F332 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F371 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F372 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F431 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F441 11/6/2012</p> <p>Cross refer to CMS 2567-L Survey report date completed 10/16/2012, F502 11/6/2012</p>
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	<p>(b) Diarrhea, (c) Jaundice, (d) Sore throat with fever, or (e) A lesion containing pus such as a boil or infected wound that is open or draining and is: (i) On the hands or wrists, unless an impermeable cover such as a finger cot or stall protects the lesion and a SINGLE-USE glove is worn over the impermeable cover, (ii) On exposed portions of the arms, unless the lesion is protected by an impermeable cover, or 32 (iii) On other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; (2) Has an illness diagnosed by a HEALTH PRACTITIONER due to: (a) Norovirus, (b) Hepatitis A virus, (c) Shigella spp., (d) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or (e) Salmonella Typhi; Reportable past illness (3) Had a previous illness, diagnosed by a HEALTH PRACTITIONER, within the past 3 months due to Salmonella Typhi, without having received antibiotic therapy, as determined by a HEALTH PRACTITIONER; Reportable history of exposure (4) Has been exposed to, or is the suspected source of, a CONFIRMED DISEASE OUTBREAK, because the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE consumed or prepared FOOD implicated in the outbreak, or consumed FOOD at an event prepared by a PERSON who is infected or ill with: (a) Norovirus within the past 48 hours of the last exposure,</p>	<p>1. E24 and E25 have new forms with correct signatures which have been reviewed by the Food Service Director and are deemed free of foodborne illnesses that would prevent them from working with food.</p> <p>2. An audit of all food service staffs' "Conditional Employee &amp; Food Employee Interview" forms will be conducted by the Food Service Director for compliance.</p> <p>3. Education will be provided by the NHA or designee to the Food Service Director and HR Director regarding the "Conditional Employee &amp; Food Employee Interview" to ensure compliance. A bi-weekly compliance audit will be conducted by Food Services Director or designee regarding "Conditional Employee &amp; Food Employee Interview" forms Any variances will be immediately corrected and documented on the monthly CQI report.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p> <p style="text-align: right;">11/7/12</p>
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	<p>(b) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or Shigella spp. within the past 3 days of the last exposure,            (c) Salmonella Typhi within the past 14 days of the last exposure, or            (d) Hepatitis A virus within the past 30 days of the last exposure; or Reportable history of exposure            (5) Has been exposed by attending or working in a setting where there is a CONFIRMED DISEASE OUTBREAK, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a CONFIRMED DISEASE OUTBREAK, or living in the same household as, and has knowledge about, an individual diagnosed with an illness caused by:            (a) Norovirus within the past 48 hours of the last exposure,            (b) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING ESCHERICHIA COLI, or Shigella spp. within the past 3 days of the last exposure,            (c) Salmonella Typhi within the past 14 days of the last exposure, or            (d) Hepatitis A virus within the past 30 days of the last exposure.            Responsibility of person in charge to notify the regulatory authority            (B) The PERSON IN CHARGE shall notify the REGULATORY AUTHORITY when a FOOD EMPLOYEE is:            (1) Jaundiced, or            (2) Diagnosed with an illness due to a pathogen as specified under Subparagraphs (A)(2)(a) - (e) of this section.            Responsibility of the person in charge to prohibit a conditional employee from becoming a food employee            (C) The PERSON IN CHARGE shall</p>	
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	<p>ensure that a <b>CONDITIONAL EMPLOYEE:</b></p> <p>(1) Who exhibits or reports a symptom, or who reports a diagnosed illness as specified under Subparagraphs (A)(1) - (3) of this section, is prohibited from becoming a <b>FOOD EMPLOYEE</b> until the <b>CONDITIONAL EMPLOYEE</b> meets the criteria for the specific symptoms or diagnosed illness as specified under § 2-201.13;P and</p> <p>(2) Who will work as a <b>FOOD EMPLOYEE</b> in a <b>FOOD ESTABLISHMENT</b> that serves as a <b>HIGHLY SUSCEPTIBLE POPULATION</b> and reports a history of exposure as specified under Subparagraphs (A)(4) - (5), is prohibited from becoming a <b>FOOD EMPLOYEE</b> until the <b>CONDITIONAL EMPLOYEE</b> meets the criteria as specified under ¶ 2-201.13(l). Responsibility of the person in charge to exclude or restrict</p> <p>(D) The <b>PERSON IN CHARGE</b> shall ensure that a <b>FOOD EMPLOYEE</b> who exhibits or reports a symptom, or who reports a diagnosed illness or a history of exposure as specified under Subparagraphs (A)(1) - (5) of this section is:</p> <p>(1) <b>EXCLUDED</b> as specified under ¶¶ 2-201.12 (A) - (C), and Subparagraphs (D)(1), (E)(1), (F)(1), or (G)(1) and in compliance with the provisions specified under ¶¶ 2-201.13(A) - (G); or</p> <p>(2) <b>RESTRICTED</b> as specified under Subparagraphs 2-201.12 (D)(2), (E)(2), (F)(2), (G)(2), or ¶¶ 2-201.12(H) or (I) and in compliance with the provisions specified under ¶¶ 2-201.13(D)- (I).</p> <p>Conditions of exclusion and restriction 2-201.12 Exclusions and Restrictions.</p>	
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	<p>The PERSON IN CHARGE shall EXCLUDE or RESTRICT a FOOD EMPLOYEE from a FOOD ESTABLISHMENT in accordance with the following: symptomatic with vomiting or diarrhea</p> <p>(A) Except when the symptom is from a noninfectious condition, EXCLUDE a FOOD EMPLOYEE if the FOOD EMPLOYEE is:</p> <p>(1) Symptomatic with vomiting or diarrhea; or</p> <p>(2) Symptomatic with vomiting or diarrhea and diagnosed with an infection from Norovirus, Shigella spp., or ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING E. COLI.P jaundiced or diagnosed with hepatitis A infection</p> <p>(B) EXCLUDE a FOOD EMPLOYEE who is:</p> <p>(1) Jaundiced and the onset of jaundice occurred within the last 7 calendar days, unless the FOOD EMPLOYEE provides to the PERSON IN CHARGE written medical documentation from a HEALTH PRACTITIONER specifying that the jaundice is not caused by hepatitis A virus or other fecal-orally transmitted infection;</p> <p>(2) Diagnosed with an infection from hepatitis A virus within 14 calendar days from the onset of any illness symptoms, or within 7 calendar days of the onset of jaundice; or</p> <p>(3) Diagnosed with an infection from hepatitis A virus without developing symptoms. diagnosed or reported previous infection due to S. Typhi</p> <p>(C) EXCLUDE a FOOD EMPLOYEE who is diagnosed with an infection from Salmonella Typhi, or reports a previous infection with Salmonella Typhi within the past 3 months as specified under</p>	
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	<p>Subparagraph 2-201.11(A)(3). Diagnosed with an asymptomatic infection from Norovirus (D) If a FOOD EMPLOYEE is diagnosed with an infection from Norovirus and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with Shigella spp. infection and asymptomatic (E) If a FOOD EMPLOYEE is diagnosed with an infection from Shigella spp. and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with EHEC or STEC and asymptomatic (F) If a FOOD EMPLOYEE is diagnosed with an infection from ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING E. COLI, and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. symptomatic with sore throat with fever</p>	
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	<p>(G) If a <b>FOOD EMPLOYEE</b> is ill with symptoms of acute onset of sore throat with fever:            (1) <b>EXCLUDE</b> the <b>FOOD EMPLOYEE</b> who works in a <b>FOOD ESTABLISHMENT</b> serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>; or            (2) <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b> who works in a <b>FOOD ESTABLISHMENT</b> not serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, symptomatic with uncovered infected wound or pustular boil            (H) If a <b>FOOD EMPLOYEE</b> is infected with a skin lesion containing pus such as a boil or infected wound that is open or draining and not properly covered as specified under Subparagraph 2-201.11(A)(1)(e), <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b>.            exposed to foodborne pathogen and works in food establishment serving HSP            (I) If a <b>FOOD EMPLOYEE</b> is exposed to a foodborne pathogen as specified under Subparagraphs 2-201.11(A)(4) or (5), <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b> who works in a <b>FOOD ESTABLISHMENT</b> serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>.            Asymptomatic and works in food establishment serving HSP            (b) Retain the <b>EXCLUSION</b> for the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least 24 hours and works in a <b>FOOD ESTABLISHMENT</b> that serves a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (D)(1) or (2) of this section are met. <i>Shigella</i> spp. diagnosis adjusting exclusion for food employee who was symptomatic and is now asymptomatic</p>	
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	<p>(3) If a <b>FOOD EMPLOYEE</b> was diagnosed with an infection from <b>Shigella spp.</b> and <b>EXCLUDED</b> as specified under Subparagraph 2-201.12(A)(2):</p> <p>(a) <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least 24 hours and works in a <b>FOOD ESTABLISHMENT</b> not serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) of this section are met; or retaining exclusion for food employee who was asymptomatic and is now asymptomatic</p> <p>(b) Retain the <b>EXCLUSION</b> for the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least 24 hours and works in a <b>FOOD ESTABLISHMENT</b> that serves a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) , or (E)(1) and (3)(a) of this section are met.</p> <p><b>EHEC or STEC diagnosis</b></p> <p>(4) If a <b>FOOD EMPLOYEE</b> was diagnosed with an infection from <b>ENTEROHEMORRHAGIC</b> or <b>SHIGA TOXIN-PRODUCING ESCHERICHIA COLI</b> and <b>EXCLUDED</b> as specified under Subparagraph 2-201.12(A)(2): adjusting exclusion for food employee who was symptomatic and is now asymptomatic</p> <p>(a) <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least 24 hours and works in a <b>FOOD ESTABLISHMENT</b> not serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (F)(1) or (2) of this section are met; or retaining</p>	
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DATE SURVEY COMPLETED: September 21, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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	<p>Subparagraph 2-201.11(A)(3). Diagnosed with an asymptomatic infection from Norovirus (D) If a FOOD EMPLOYEE is diagnosed with an infection from Norovirus and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with Shigella spp. infection and asymptomatic (E) If a FOOD EMPLOYEE is diagnosed with an infection from Shigella spp. and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. Diagnosed with EHEC or STEC and asymptomatic (F) If a FOOD EMPLOYEE is diagnosed with an infection from ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING E. COLI, and is ASYMPTOMATIC: (1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or (2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION. symptomatic with sore throat with fever</p>	<p><i>CROSS REFER F371</i></p> <ol style="list-style-type: none"> <li>1. No residents are identified as being affected by the practice.             <ol style="list-style-type: none"> <li>1a. Identified items in the Traulsen Reach-in Refrigerator that were unlabeled, undated, and/or open were immediately discarded.</li> <li>1b. Identified items in the Walk-in Freezer (outside) that were unlabeled, undated, open and/or did not have expiration dates were immediately discarded.</li> <li>1c. Identified items in the Walk-in Refrigerator (inside) that were open without date, unlabeled, undated, and/or thawed without identifying label were immediately discarded. E21, E22, and E23 received education regarding cover/label/date; expiration dates on items when removed from original packaging; sanitation; thermometer calibration; and proper holding of cold foods to maintain safe holding temperatures not to exceed 40 degrees F.</li> </ol> </li> <li>2. New thermometers were immediately obtained from the Food Services Director inventory to ensure accuracy of measurement.</li> <li>3. The 3-compartment sink was immediately cleaned of visible debris. The contracted vendor for pest control (Western) was immediately notified and inspected the area the evening of 9/11/2012 with a documented report of no pests in the pantry or specifically, in the area identified with the sighting. The drinking glasses were sanitized.</li> </ol>
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	<p>(G) If a <b>FOOD EMPLOYEE</b> is ill with symptoms of acute onset of sore throat with fever:  <b>(1) EXCLUDE the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION; or</b>  <b>(2) RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT not serving a HIGHLY SUSCEPTIBLE POPULATION.</b>  <b>symptomatic with uncovered infected wound or pustular boil</b>  <b>(H) If a FOOD EMPLOYEE is infected with a skin lesion containing pus such as a boil or infected wound that is open or draining and not properly covered as specified under Subparagraph 2-201.11(A)(1)(e), RESTRICT the FOOD EMPLOYEE.</b>  <b>exposed to foodborne pathogen and works in food establishment serving HSP</b>  <b>(I) If a FOOD EMPLOYEE is exposed to a foodborne pathogen as specified under Subparagraphs 2-201.11(A)(4) or (5), RESTRICT the FOOD EMPLOYEE who works in a FOOD ESTABLISHMENT serving a HIGHLY SUSCEPTIBLE POPULATION.P</b>  <b>Asymptomatic and works in food establishment serving HSP</b>  <b>(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (D)(1) or (2) of this section are met. Shigella spp. diagnosis adjusting exclusion for food employee who was symptomatic and is now asymptomatic</b></p>	<p>2. All residents have the potential to be affected by this practice.  All refrigeration and freezer storage areas were immediately audited by Food Service Director on 9/11/2012 to ensure compliance with standards (cover/label/date/expiration date when out of original package) with no other variances identified.  The Food Service Director audited the calibration of the thermometers used throughout all food areas and found no other faulty thermometers.  The Food Service Director initiated an audited conducted before and after each service of 3-compartment sink and no there were no sanitation variances with no visible debris.  The Food Service Director initiated a daily audit for surveillance of pests and no pests were sighted. This was confirmed by the documented report from the facility's pest control vendor (Western).</p> <p>3. Education will be provided to all Food Service staff regarding standards as reflected in facility policies (FB-6048 Safe Food Temperatures; FB-6113 Pest Control; FB-6108 Food Safety in Receiving and Storage; FD-AL/IL-504.F2 Guidelines for Checking Food Temps) and the "Conditional Employee &amp; Food Employee Interview". Specifically, the education provided will include cover/label/date; expiration dating when food out of original package; safe food temperatures and calibration of thermometers; sanitation of food service areas (including 3-compartment sinks) and pest surveillance and reporting.</p> <p>Education will be provided by the NHA or designee to the Food Service Director and HR Director regarding the "Conditional Employee &amp; Food Employee Interview" to ensure compliance.</p>



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	<p>(3) If a <b>FOOD EMPLOYEE</b> was diagnosed with an infection from <b>Shigella spp.</b> and <b>EXCLUDED</b> as specified under Subparagraph 2-201.12(A)(2):</p> <p>(a) <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least <b>24 hours</b> and works in a <b>FOOD ESTABLISHMENT</b> not serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) of this section are met; or retaining exclusion for food employee who was asymptomatic and is now asymptomatic</p> <p>(b) Retain the <b>EXCLUSION</b> for the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least <b>24 hours</b> and works in a <b>FOOD ESTABLISHMENT</b> that serves a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (E)(1) or (2) , or (E)(1) and (3)(a) of this section are met.</p> <p><b>EHEC or STEC diagnosis</b></p> <p>(4) If a <b>FOOD EMPLOYEE</b> was diagnosed with an infection from <b>ENTEROHEMORRHAGIC</b> or <b>SHIGA TOXIN-PRODUCING ESCHERICHIA COLI</b> and <b>EXCLUDED</b> as specified under Subparagraph 2-201.12(A)(2): adjusting exclusion for food employee who was symptomatic and is now asymptomatic</p> <p>(a) <b>RESTRICT</b> the <b>FOOD EMPLOYEE</b>, who is <b>ASYMPTOMATIC</b> for at least <b>24 hours</b> and works in a <b>FOOD ESTABLISHMENT</b> not serving a <b>HIGHLY SUSCEPTIBLE POPULATION</b>, until the conditions for reinstatement as specified under Subparagraphs (F)(1) or (2) of this section are met; or retaining</p>	<p>A bi- weekly compliance audit will be conducted by Food Services Director or designee regarding:</p> <ol style="list-style-type: none"> <li>1. All refrigeration and freezer areas for cover/label/date; expiration dating when out of original package</li> <li>2. Thermometers for proper calibration</li> <li>3. Sanitation in food service areas</li> <li>4. Pest surveillance</li> <li>5. "Conditional Employee &amp; Food Employee Interview" forms</li> </ol> <p>Any variances will be immediately corrected and documented on the monthly CQI report.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p>
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	<p>exclusion for food employee who was symptomatic and is now asymptomatic and works in food establishment serving HSP</p> <p>(b) Retain the EXCLUSION for the FOOD EMPLOYEE, who is ASYMPTOMATIC for at least 24 hours and works in a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION, until the conditions for reinstatement as specified under Subparagraphs (F)(1) or (2) are met.</p> <p>hepatitis A virus or jaundice diagnosis -see regs for additional requirements</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Example 4.</p> <p><b>3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD.</b></p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Examples 1 and 2.</p> <p><b>3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety</b></p>	
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	<p>Food), Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, <b>POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD)</b> shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130oF) or above; or (2) At 5°C (41°F) or less.</p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Example 2.</p> <p><b>3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking.</b> (A) Except when <b>PACKAGING FOOD</b> using a <b>REDUCED OXYGEN PACKAGING</b> method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, <b>READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD)</b> prepared and held in a <b>FOOD ESTABLISHMENT</b> for more than 24 hours shall be clearly marked to indicate the date or day by which the <b>FOOD</b> shall be consumed on the <b>PREMISES</b>, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. (B) Except as specified in ¶¶ (D) - (F) of this section, refrigerated, <b>READY-TO-EAT, POTENTIALLY</b></p>	
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	<p><b>HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD)</b> prepared and <b>PACKAGED</b> by a <b>FOOD PROCESSING PLANT</b> shall be clearly marked, at the time the original container is opened in a <b>FOOD ESTABLISHMENT</b> and if the <b>FOOD</b> is held for more than 24 hours, to indicate the date or day by which the <b>FOOD</b> shall be consumed on the <b>PREMISES</b>, sold, or discarded, based on the temperature and time combinations specified in ¶(A) of this section and: (1) The day the original container is opened in the <b>FOOD ESTABLISHMENT</b> shall be counted as Day 1; and (2) The day or date marked by the <b>FOOD ESTABLISHMENT</b> may not exceed a manufacturer's use-by date if the manufacturer determined the use- by date based on <b>FOOD</b> safety. (C) A refrigerated, <b>READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD)</b> ingredient or a portion of a refrigerated, <b>READY-TO- EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD)</b> that is subsequently combined with additional ingredients or portions of <b>FOOD</b> shall retain the date marking of the earliest- prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (2) Marking the date or day of preparation, with a procedure to discard the <b>FOOD</b> on or before the last date or day by which the <b>FOOD</b> must be consumed on the premises, sold, or discarded as specified under ¶ (A) of</p>	
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	<p>this section;</p> <p>(3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or</p> <p>(4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.</p> <p>(6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original CASING on the product; and</p> <p>(7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Examples 1 and 2.</p> <p><b>3-602.11 Food Labels.</b></p> <p>(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.</p> <p>(B) Label information shall include:</p>	
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	<p>(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement;</p> <p>(2) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD;</p> <p>(4) The name and place of business of the manufacturer, packer, or distributor; and</p> <p>(5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient (Effective January 1, 2006).</p> <p>(6) Except as exempted in the Federal Food, Drug, and Cosmetic Act § 403(Q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling.</p> <p>(C) Bulk FOOD that is available for CONSUMER self-dispensing shall be prominently labeled with the following information in plain view of the CONSUMER:</p> <p>(1) The manufacturer's or processor's label that was provided with the FOOD; or</p> <p>(2) A card, sign, or other method of notification that includes the information specified under Subparagraphs (B)(1), (2), and (5) of this section.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371,</p>	
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	<p>Examples 1 and 2.</p> <p><b>4-502.11 Good Repair and Calibration.</b></p> <p><b>(B) FOOD TEMPERATURE MEASURING DEVICES shall be calibrated in accordance with manufacturer's specifications as necessary to ensure their accuracy.</b></p> <p><b>(C) Ambient air temperature, water pressure, and water TEMPERATURE MEASURING DEVICES shall be maintained in good repair and be accurate within the intended range of use.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Example 2.</p> <p><b>5-501.113 Covering Receptacles.</b></p> <p><b>Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered:</b></p> <p><b>(A) Inside the FOOD ESTABLISHMENT if the receptacles and units:</b></p> <p><b>(1) Contain FOOD residue and are not in continuous use; or</b></p> <p><b>(2) After they are filled;</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F372.</p> <p><b>6-501.114 Maintaining Premises, Unnecessary Items and Litter.</b></p> <p><b>The PREMISES shall be free of: (B)</b></p>	<p>1. No residents are identified as being affected by the practice.</p> <p>2. The large garbage barrel was immediately removed and a replacement lid ordered, received, and placed into service. The Food Service Director conducted an immediate audit of all other garbage barrels within the food services areas and no variances were identified.</p> <p>3. Education will be provided with all food service staff regarding the standards and facility policy for garbage containers to be leak-proof, nonabsorbent, and with close-fitting covers. Additionally, the food service staff will be educated regarding variance reporting to the Food Service Director. A bi-weekly audit will be conducted by the Food Service Director of designee of all garbage containers to ensure that they are compliant with standards and policy (leak-proof, nonabsorbent, and with close-fitting covers). Variances will be immediately corrected and documented on the monthly CQI report.</p> <p>4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QA&amp;A meeting for compliance. The frequency of the audits will be adjusted according to outcomes.</p> <p style="text-align: right;">11/6/12</p> <p><i>CROSS REFER TO CMS 2567-L REPORT 10/16/12 F372</i></p>
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	<p><b>Litter.</b></p> <p><b>This requirement was not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed, 9/21/12, F371, Example 3.</p>	<p><i>CROSS REFER TO CMS 2567-L SURVEY REPORT 10/10/12 F371 11/6/12</i></p>
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