

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/01/2015
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NAME OF PROVIDER OR SUPPLIER REGENCY HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806
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F 000	<p>INITIAL COMMENTS</p> <p>Revised report following the Informal Dispute Resolution conducted on 10/27/2015. The following changes were made to the report: F279 was deleted. F309 no changes were made. Scope and severity remains the same. F332 Text changes made to the tag. No change to scope and severity.</p> <p>An unannounced annual and complaint survey was conducted at this facility from August 24, 2015 through September 1, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 92. The Stage 2 survey sample size was 35.</p> <p>Abbreviations/definitions used in this 2567 are as follows:</p> <ul style="list-style-type: none"> > - greater than; < - less than; + positive for; - negative for; ABT - antibiotic; Acute renal (kidney) failure (ARF) - the kidneys suddenly become unable to filter waste products from your blood which can be fatal/deadly; ADL - Activities of Daily Living/ADL/bathing, eating, toileting and hygiene; ADON - Assistant Director of Nursing; ALS-Advanced Life Support; AKI- acute kidney injury; Analgesia - relief of pain, usually achieved with 	F 000	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	11/1/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diana M. Stevens NHA</i>	TITLE	(X6) DATE <i>11/1/15</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 000	Continued From page 1 medications; Anticoagulant - medication that work to prevent the clotting of blood; Aspiration pneumonia-occurs when food or liquid is breathed into the lungs; BLS-Basic Life Support; BIMS - Brief Interview for Mental Status/tool used to measure mental abilities; BiPAP - machine that helps the patient breathe; BMP - Basic Metabolic Panel; BUN - blood urea nitrogen; Carbon Dioxide - (CO2) gas formed during breathing; CBC - complete blood cell count; CNA - Certified Nurse's Aide; C/O- complained of; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; COPD - chronic obstructive pulmonary disease-progressive lung disease that makes it hard to breathe; Creatinine - increased quantities found with renal /kidney disease; C/S (Culture & Sensitivity) - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; CTA-(clear to auscultation)-lungs clear; no abnormal sounds audible; CVA- Cerebral Vascular Accident or Stroke; CXR- chest x-ray; Dehydration - a condition in which the body has less than normal fluid; Desaturation- decreased oxygen in the blood resulting from conditions affecting the exchange of oxygen and carbon dioxide; Diuretics - medicines that help reduce the amount	F 000		11/4/15
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F 000	<p>Continued From page 2 of water/excess fluid in the body; DNR - do not resuscitate (perform heroic measures such as CPR); DON - Director of Nursing; dysphagia - difficulty swallowing; d/t-due to; E. coli (Escherichia coli) - type of bacteria commonly found in the gastrointestinal (GI) tract; Edentulous - toothless; Elopement - an act or instance of leaving a safe area or safe premises; ER-Emergency Room; EVS Director - Environmental Services Director; Expressive aphasia - loss of ability to produce language, spoken or written; F (Fahrenheit) - temperature scale; FDA - Food and Drug Administration/a United States federal agency responsible for protecting and promoting public health through regulation and supervision of food safety; Febrile- having an elevated temperature; FSD - Food Service Director; F/U-follow up; Gerichair - recliner; Hematoma - collection of blood under the skin as a result of trauma (fall); Hoyer Lift - mechanical lift that requires a sling; Hoyer Sling - assistive device made of fabric placed under to cradle the resident then attached to hoyer lift hooks which hold the weight of the resident while suspended in the air; Hospice - end of life care; Hyponatremia- high salt or sodium blood level due to a decrease in total body water; Icy hot patch - pain relieving ointment on a breathable adhesive pad that is applied to the skin; IDT - Interdisciplinary Team; Intubated - placement of a flexible plastic tube</p>	F 000		11/1/15



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F 000	<p>Continued From page 3</p> <p>into the windpipe to maintain an open airway; IV - Intravenous - within the veins, or administration of medications/fluids through a tube directly into a vein; L-liters; lbs. - pounds; Lethargy- abnormal drowsiness; Malaise - weakness, lack of energy and vague sense of not feeling well; MAR - Medication Administration Record; MD - Medical Doctor; MDS - Minimum Data Set-standardized assessment form used in nursing homes; mech - mechanics; Microorganisms - single-celled organisms such as bacteria, not visible to the naked eye, that may be harmful; Milligram (mg), A unit of mass; Nasal cannula- tube placed into nostrils to deliver oxygen; Nebulizer - a drug delivery device used to administer medication in the form of a mist inhaled into the lungs; NHA - Nursing Home Administrator; NN- nurse's note; NP-Nurse Practitioner; NRB (non-rebreather mask) - enables delivery of high concentrations of oxygen; O2 - oxygen; Oxycodone IR- immediate release strong pain medication; PNA (pneumonia) - lung infection; POA - power of attorney; POS - Physician's Order Sheet; PRN - as needed; pt's - patient's; Pulmonary embolism - blood clots that travel to the lungs; PO2-Pulse Oximetry - measures blood oxygen</p>	F 000		11/11/15

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F 000	<p>Continued From page 4</p> <p>saturation levels - desired range 94% to 100%; RD - Registered Dietitian; Respiratory failure- inability of the lungs to perform basic task of gas exchange; lack of oxygen and/or excess carbon dioxide; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; R/O - rule out; look for; RR- respiratory rate; breathing per minute; R/T - related to; Sepsis - potentially deadly medical condition characterized by a whole-body inflammatory state; SOB- shortness of breath; s/p - status post; STAT-urgent or rush; Straight cath- hollow tube inserted into bladder to obtain urine; T - temperature; TAR - Treatment Administration Record; tech - technique; txfr - transfer; U/A (Urinalysis) - diagnostic test used to detect and assess a disease or illness OR diagnostic test used to determine presence of infection; UM - Unit Manager; URI - upper respiratory infection; Urinary incontinence- inability to prevent accidental leakage of urine from bladder; UTI - Urinary Tract Infection; Vital signs - clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure that indicate the state of a patient's essential body functions; WBC-white blood count; Xarelto - anticoagulant/medication that increases the amount of time it takes for blood to clot.</p>	F 000		11/11/15
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<p>F 157 F 157 SS=E</p>	<p>Continued From page 5 483.10(b)(11) NOTIFY OF CHANGES (INJURY/ DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to immediately</p>	<p>F 157 F 157</p>	<p>F157</p> <p>A. R121 no longer resides at the facility.</p> <p>B. All residents have the potential to be affected by this deficient practice.</p> <p>C. (1) The Interdisciplinary Team (IDT) which includes the Medical Director will review and revise the "Physician Notification of Condition" policy. Revisions will be made in accordance with AMDA's guidelines for identifying Acute Change in the Elderly. (2) The Staff Developer will educate the licensed nursing staff on the revised policy. (2) Now during morning meeting the IDT identifies residents on the 24 hour report that exhibit signs and symptoms that warrant physician notification. The team monitors that the physician was notified. If the policy was not followed the physician will be notified accordingly.</p>	<p>11/11/15</p>
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F 157	<p>Continued From page 6</p> <p>notify R121's physician when there was a change in condition, on multiple occasions, with potential for requiring physician intervention for one (R 121) out of 35 sampled stage 2 residents. Findings include:</p> <p>Cross refer F309, example #1</p> <p>The facility Notification of Condition Change: Physician policy, last revised in 11/2010, stated, "... nurses are responsible to provide timely and complete communication to physician's when there is a change in condition... Types of condition that may require notification of the physician: ... altered mental status... change in vital signs including temperature... pain... Document assessment data, attempted or actual correspondence with physician, and physician's response in the medical record...".</p> <p>R121 was evaluated by a physician on 12/23/14 and 12/24/15. A CXR and u/a and c/s were ordered on 12/23/14. The CXR was negative for pneumonia. The urine studies were ordered to rule out a UTI. The physician wrote on 12/24/14 that R121's illness appeared to be viral.</p> <p>Chart review revealed the following:</p> <p>12/25- lethargic, desaturated to 85% PO2 with SOB- O2 applied. c/o severe pain all over- Percocet given. T 99.4 F. R121 receives Tylenol 650 mg po twice a day on a routine basis;</p> <p>12/26- continued to require nasal O2 and T 99.4 F;</p> <p>12/27- continued to require O2. T 100.5 F- Tylenol given and recheck T 99.8 F;</p> <p>12/28- u/a and c/s collected;</p> <p>12/29- continued to require O2; high risk meeting</p>	F 157	<p>D.</p> <p>(1) The DON/designee will conduct weekly audits on all 24 hour reports to monitor that the physician was notified as per policy. Attachment 1.</p> <p>(2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved</p>	<p>11/14/15</p> <p>↓</p>
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F 157	Continued From page 7 held (no physician progress note); 12/30- lethargic, poor appetite, T 99.3 F; 12/31- seen by MD after nursing requested review of urine c/s results- started ABT for UTI. Although R121 required daily use of O2, had low grade temperatures requiring prn Tylenol (despite routine Tylenol), decreased appetite and decreased mental status, the facility failed to notify the MD of R121's decline in status in a timely manner.	F 157		11/11/15 ↓	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system	F 159	A. (1) The facility is now maintaining R33's personal funds in the accordance with generally accepted accounting principles. B. (1) All residents that have their personal funds maintained by the facility have the potential to be affected by this deficient practice. (2) The Business Office/designee will audit all resident funds maintained by the facility. The audits will include that residents are accruing interest monthly, and the ledger clearly shows all debits and credits. Corrections will be made accordingly.	11/11/15 ↓	

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F 159	<p>Continued From page 8</p> <p>that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record and accounting review and interview, it was determined that the facility failed to ensure and to employ proper bookkeeping technique for one (R33) out of 35 Stage 2 sampled residents, in accordance with the generally accepted accounting principles. Findings include:</p> <p>Review of copies of R33's bank statements dated 1/1-31/15, 2/1-28/15, 3/1-31/15, 4/1-30/15, 5/1-31/15, 6/1-30/15 and 7/1-31/15 provided by the facility to the surveyor on 8/25/15 showed that R</p>	F 159	<p>C.</p> <p>(1) The facility has implemented resident's accruing interest monthly versus quarterly. (2) Generally accepted principles of accounting have been implemented and the resident's ledgers now accurately reflect all debits and credits.</p> <p>D.</p> <p>(1) The Business Officer/designee will conduct monthly audits on all resident's accounts held by the facility to monitor that monthly interest is being accrued and for the accuracy of the ledger. Attachment 2 (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	<p>11/11/15</p>
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(Signature)
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F 159	<p>Continued From page 9</p> <p>33 was receiving from Social Security via electronic credit, the amount of \$844 deposited into this resident's personal funds account. However, review of R33's copy of the Ledger account failed to show that the full amount of \$ 844.00 was posted/credited on his ledger each month. Additionally, the withdrawal of \$44.00 (personal funds) was not posted or shown on the debit account.</p> <p>During an interview with E1 (NHA) on 8/31/15 at approximately 10:55 AM, she stated that the debit and credit on R33's ledger account was not clear.</p> <p>Additionally, R33's quarterly statement dated 4/1/ 15 through 6/30/15 given to the family, failed to show or post the full amount of the Social Security payment on this resident's funds statement.</p> <p>During an interview with E15 (Business Office Manager) on 9/1/15 at approximately 8:45 AM, E 15 stated that the Social Security payment should have been posted as a credit/deposit in full on R 33's ledger account and the withdrawal should have been posted on the debit, which was not shown. The full Social Security payment should have been shown on R33's funds statement given to the family and it was not showing on R33 's statement.</p> <p>The facility failed to assure a full and complete accounting of R33's personal funds entrusted to the facility on his behalf according to generally accepted accounting principles.</p> <p>E1 acknowledged this finding during an interview on 9/1/15 at approximately 4:00 PM.</p>	F 159		11/1/15
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<p>F 202 F 202 SS=D</p>	<p>Continued From page 10 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented . The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record reviews and interviews, it was determined that for two (R27 and R121) out of 35 Stage 2 sampled residents, the facility failed to have the primary physician document discharge summaries that were complete and accurate. Findings include:</p> <p>1. R27 was admitted to the facility on 7/11/15 and discharged to the hospital on 8/4/15.</p> <p>Review of R27's clinical record lacked evidence of a completed discharge summary.</p> <p>Findings were reviewed with E2 (DON) on 9/1/15 at 12:25 PM. The facility failed to ensure that a physician's discharge summary was completed for R27.</p> <p>2. R121 was admitted to the facility on 10/31/12 and discharged to the hospital on 1/2/15.</p> <p>Review of the discharge summary revealed that the physician incorrectly documented a discharge</p>	<p>F 202 F 202</p>	<p>F202</p> <p>A.</p> <p>(1) The attending physician for R121 is no longer practicing at Regency thus corrections to the discharge summary cannot be made.</p> <p>(2) The attending physician for R27 is no longer practicing at Regency thus corrections to the discharge summary cannot be made.</p> <p>B.</p> <p>(1) All residents that are discharged from the facility have the potential to be affected by this deficient practice. (2) The Medical Records Clerk/designee will audit the discharge summary of all residents discharged from the facility within the last 30 days. Audits will monitor for the correct discharge date, pertinent physical and laboratory findings and course of treatment. Attending physician will be contacted accordingly to make necessary changes.</p>	<p>11/11/15</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/01/2015
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NAME OF PROVIDER OR SUPPLIER REGENCY HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806
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(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
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F 202	<p>Continued From page 10 or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R27 and R121) out of 35 Stage 2 sampled residents, the facility failed to have the primary physician document discharge summaries that were complete and accurate. Findings include:</p> <p>1. R27 was admitted to the facility on 7/11/15 and discharged to the hospital on 8/4/15.</p> <p>Review of R27's clinical record lacked evidence of a completed discharge summary.</p> <p>Findings were reviewed with E2 (DON) on 9/1/15 at 12:25 PM. The facility failed to ensure that a physician's discharge summary was completed for R27.</p> <p>2. R121 was admitted to the facility on 10/31/12 and discharged to the hospital on 1/2/15.</p> <p>Review of the discharge summary revealed that the physician incorrectly documented a discharge date of 1/9/15 when the actual discharge date was 1/2/15. Additionally, the discharge summary was incomplete; it lacked a brief history, pertinent physical and laboratory findings, and the course of treatment.</p> <p>Findings were reviewed with E1 (NHA) and E2 during an interview on 9/1/15 at approximately 3 PM.</p>	F 202	<p>C.</p> <p>(1) All physicians that have privileges at Regency will be contacted by NHA/designee regarding the need to write complete and accurate discharge summaries. Complete and accurate summaries include but are not limited to the correct discharge date, pertinent physical and laboratory findings and course of treatment.</p> <p>(2) The Medical Record Clerk has begun discussing discharge summaries with the IDT during the morning meeting to determine if they are complete and accurate. Physicians will be contacted accordingly.</p>	11/11/15
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11/4/15
(J)

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F 202	<p>Continued From page 11 date of 1/9/15 when the actual discharge date was 1/2/15. Additionally, the discharge summary was incomplete; it lacked a brief history, pertinent physical and laboratory findings, and the course of treatment.</p> <p>Findings were reviewed with E1 (NHA) and E2 during an interview on 9/1/15 at approximately 3 PM.</p> <p>The facility failed to have an accurate and complete discharge summary for R121.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/ REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must</p>	F 202	<p>D.</p> <p>(1) The Medical Record Clerk/designee will conduct weekly audits on all summaries written in that time frame. Audits will monitor for correct discharge date, pertinent physical and laboratory findings and course of treatment. Attachment 3.</p> <p>(2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p> <p>F 225</p> <p>F225</p> <p>A.</p> <p>(1) R15 no longer resides at the facility.</p> <p>B.</p> <p>(1) All residents have the potential to be affected by this deficient practice. (2) The NHA/designee will audit all investigations conducted within the last 30 days to monitor for thoroughness and timeliness of reporting to DLTCRP. Additionally statements and investigation will be done accordingly.</p>	11/1/15
F 225 SS=D		F 225		

(Signature)
11/4/15

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 12</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review, interview and review of facility documentation, it was determined that for one (R15) out of 35 Stage 2 sampled residents, the facility failed to have evidence that R15's fall on 1/3/15 was thoroughly investigated and failed to report the fall within 8 hours as required by Delaware State law to the Division of Long Term Care Residents Protection (DLTCRP). Findings include:</p> <p>The facility's fall prevention guideline, last revised on 10/13/14, stated, "... The nurse will initiate an investigation after a resident falls in effort to determine a possible cause ... The Interdisciplinary Team (IDT) during the next morning meeting will review any resident fall. The team will try and determine a possible cause ... The team will also review the investigation and determine if the appropriate interventions were implemented and what additional measures, if any, may be necessary to provide safety for the residents ...".</p> <p>R15 was admitted to the facility on 6/19/13.</p>	F 225	<p>C.</p> <p>(1) The Staff Developer will educate all nursing supervisors on the need to notify DLTCRP within 8 hours of a reportable incident. (2) The Staff Developer will educate nursing staff and IDT on how to conduct a thorough investigation. (3) Now all investigations will be reviewed by the NHA before the investigation is closed. Investigations will be monitored for thoroughness and adherence to DLTCRP reporting guidelines. Additionally investigation will be conducted accordingly.</p> <p>D.</p> <p>(1)The NHA/designee will audit investigations for thoroughness and adherence to the reporting guidelines. Attachment 4 (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/15

(Signature)
11/11/15

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F 225	<p>Continued From page 13</p> <p>According to the facility's incident report, dated 1/3/15 and timed 2:43 PM, R15 was being transferred from her bed to the geri-chair at 11:50 AM with two CNA's using a hoier lift and she slid off the hoier sling and fell. R15 sustained a hematoma to the back and right side of her head. R15 was sent to the emergency room for evaluation.</p> <p>The statements of the two CNAs (E16 and E17), dated 1/3/15, were as follows: 1. E16 stated, "I and E17 was (sic) getting R15 up with lift and R15 cam (sic) of (sic) of the top and R15 hit the bar". 2. E17 stated, "... was getting R15 up with E16 helping me. We was (sic) using the lift and R15 came off the top and R15 hit the bar". It was unclear after reviewing the facility's incident report and the two CNA statements as to how the fall occurred.</p> <p>A nurse's note, dated 1/3/15 and timed 11:24 PM, stated that R15 returned to the facility at 8:40 PM from the emergency room.</p> <p>On 1/4/15 at 2:03 PM, the facility reported the fall to the DLTCRP, over 24 hours later. The facility failed to notify the DLTCRP within 8 hours of the fall as required by Delaware State law.</p> <p>A nurse's note, dated 1/5/15 and timed 10:20 AM, stated, "IDT meeting ... reviewed fall, spoke with witness, Rehab to eval technique and equipment (sic) R/T hoier transfers". It was unclear in R15's clinical record as to which witness was re-interviewed and what information was obtained.</p> <p>An Occupational Therapy evaluation, dated 1/7/</p>	F 225		1/14/15
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1/14/15

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

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F 225	<p>Continued From page 13</p> <p>The statements of the two CNAs (E16 and E17), dated 1/3/15, were as follows:</p> <ol style="list-style-type: none"> 1. E16 stated, "I and E17 was (sic) getting R15 up with lift and R15 cam (sic) of (sic) of the top and R15 hit the bar". 2. E17 stated, "... was getting R15 up with E16 helping me. We was (sic) using the lift and R15 came off the top and R15 hit the bar". <p>It was unclear after reviewing the facility's incident report and the two CNA statements as to how the fall occurred.</p> <p>A nurse's note, dated 1/3/15 and timed 11:24 PM, stated that R15 returned to the facility at 8:40 PM from the emergency room.</p> <p>On 1/4/15 at 2:03 PM, the facility reported the fall to the DLTCRP, over 24 hours later. The facility failed to notify the DLTCRP within 8 hours of the fall as required by Delaware State law.</p> <p>A nurse's note, dated 1/5/15 and timed 10:20 AM, stated, "IDT meeting ... reviewed fall, spoke with witness, Rehab to eval technique and equipment (sic) R/T hoier transfers". It was unclear in R15's clinical record as to which witness was re-interviewed and what information was obtained.</p> <p>An Occupational Therapy evaluation, dated 1/7/15 and timed 3 PM, stated, "... s/p fall during txfr who benefits from caregiver re-education on proper body mech and hoier txfr tech. On 1/6/15 pt's caregivers provided with training on hoier lift canvas selction (sic), proper body mech and hoier transfer tech with good carry over from caregivers ...".</p>	F 225		11/11/15

- 10
9/27/15

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F 225	<p>Continued From page 14</p> <p>15 and timed 3 PM, stated, "... s/p fall during txfr who benefits from caregiver re-education on proper body mech and hoyer txfr tech. On 1/6/15 pt's caregivers provided with training on hoyer lift canvas selction (sic), proper body mech and hoyer transfer tech with good carry over from caregivers ...".</p> <p>In an interview on 8/31/15 at 8:23 AM, E18 (Rehab Director) stated that the IDT requested her to re-educate CNA's on proper safety techniques, body mechanics, pacing/timing with hoyer lifts and how to hook up the canvases (slings). E18 stated that she was not aware of the details of R 15's fall.</p> <p>Findings were reviewed with E2 (DON) on 9/1/15 at approximately 12:30 PM. The facility lacked evidence that R15's fall on 1/3/15 was thoroughly investigated and failed to report the fall within 8 hours to the DLTCRP as required by State law.</p>	F 225		11/11/15
F 246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on observation and interview, it was determined that the facility failed to provide a reasonable accommodation of individual needs</p>	F 246	<p>F 246</p> <p>A.</p> <p>(1) R30's over bed light pull has been replaced with a longer cord.</p> <p>(2) The facility cannot retroactively provide R90's, R122's and R33's their call bells that were noted as being out of reach during survey.</p> <p>B.</p> <p>(1) All residents have the potential to be affected by this deficient practice. (2) The Maintenance Director/designee will check the length of the light pull cord for all residents. Pull cords will be replaced accordingly.</p>	

11/11/15
JD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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09/01/2015

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REGENCY HEALTHCARE & REHAB CENTER

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801 N. BROOM STREET
WILMINGTON, DE 19806

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F 246

Continued From page 15 for four (R30, R33, R90, and R122) out of 35 sampled residents. The facility failed to ensure that R30's overbed light pull cord was long enough for the resident to reach, in order to operate the light. For R33, R90 and R122, the facility failed to ensure that call bells were within reach. Findings include:

1. During an interview on 8/25/15 at 11:32 AM, R 30 stated that she was unable to reach the overbed light pull cord when she was in bed because it was too short. Observation of the overbed light revealed the pull cord ended several inches above the headboard.

During an environmental tour on 9/1/15 at approximately 2:05 PM, findings were confirmed by E11 (EVS Director).

2. On 8/28/15 at 8:07 AM, R90 was observed lying on his bed. R90 stated he was having pain and asked this surveyor if I saw his call light. Observation revealed that the call light was on the floor under R90's bed. R90 was given the call bell and proceeded to press it to request pain medication. The facility failed to ensure R90's call light was within reach at all times.

Findings were confirmed by E6 (RN/UM) immediately after the observation.

3. Observation on 8/24/15 at 3:20 PM revealed R 122 lying on his bed. The call bell was observed on the floor out of the resident's reach. The facility failed to ensure R122's call light was within reach at all times.

Findings were reviewed with E1 (NHA) and E2 (DON) during an interview on 9/1/15 at

F 246

C.
(1) Since the survey the Maintenance Director placed the light pull cords into the facility's electronic preventive management system (TELS). Now maintenance will check the length of the cord twice per month as part of the facility's preventive maintenance program. (2) The facility will now have the lead C.N.A. make rounds on all residents' to monitor that call bells are within reach.(3) The Staff Developer will educate nurses and C.N.A's on the need to keep the call bell within reach at all times.

D.
(1) The Maintenance Director/designee will conduct weekly audits on the length of pull cords. Attachment 5. (2) The D.O.N./designee will audit daily that call bells are within reach of all resident's (3) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.

11/11/15

11/4/15

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F 246	Continued From page 16 approximately 11:45 AM. 4. Observation on 8/24/15 at 11:46 AM revealed R33 lying on his bed. The call bell was observed on the floor behind the head of the bed and out of the resident's reach. When placed within R33's reach, he was capable of using the call bell. The facility failed to ensure R33's call bell was within reach at all times.	F 246		11/4/15
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during Stage 1 of the survey and interviews made during the environmental tour on 9/1/15, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for six (6) out of 35 rooms observed. Findings include: 1. On 8/28/15 at 8:07 AM, nebulizer tubing was observed lying on the floor underneath R90's bed. Findings were reviewed with E6 (RN/UM) immediately after the observation. E6 was observed discarding the nebulizer tubing. The facility failed to ensure proper storage of R90's equipment in a sanitary manner.	F 253	A. (1) Once informed by the surveyor the staff picked up R90's nebulizer tubing. (2) The stained ceiling tile was replaced in 218's bathroom. (3) The chipped edges on 307's entry door were repainted and scratches on dresser were repaired. (4) The scrapes on the outside of 313's were repaired. (5) The chipped edges on 305's entry door were repainted. (6) The call bell in 315's bathroom was tightened. B. (1) All residents have the potential to be affected by this deficient practice. (2) The Maintenance Director/designee will audit all rooms for chipped paint on door entries, scratches on the dresser, scrapes on door, and loose call bells. Repairs will be made accordingly.	11/4/15

11/4/15
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F 253	<p>Continued From page 17</p> <p>2. Observation on 8/24/15 at 11:33 AM revealed room 218's bathroom had a stained ceiling tile.</p> <p>Findings were confirmed by E11 (EVS Director) on 9/1/15 at approximately 2:30 PM during the environmental tour.</p> <p>3. Observation on 8/24/15 at 11:19 AM of room 307 revealed that the room entry door had chipped edges and the top surface of the dresser had several scratches.</p> <p>Findings were confirmed by E11 on 9/1/15 at approximately 2:30 PM during the environmental tour.</p> <p>4. Observation on 8/24/15 at 1:47 PM of room 313 revealed scrapes on the outside of the bathroom door.</p> <p>Findings were confirmed by E11 on 9/1/15 at approximately 2:30 PM during the environmental tour.</p> <p>5. Observation on 8/24/15 at 10:50 AM of room 305 revealed chips on the side of the entry door.</p> <p>Findings were confirmed by E11 on 9/1/15 at approximately 2:30 PM during the environmental tour.</p> <p>6. Observation on 8/25/15 at 2:02 PM of room 315's bathroom revealed that although the call bell was functional, it was loose where attached to the wall.</p> <p>Findings were confirmed by E11 on 9/1/15 at approximately 2:30 PM during the environmental</p>	F 253	<p>C.</p> <p>(1) Since the survey the Maintenance Director placed doors, door entry ways, ceiling tiles and adherence of call bells into the facility's electronic preventive management system (TELS). Now maintenance will check for chipped paint, scraped doors, scratches on the dresser, condition of ceiling tiles and adherence of call bells twice per month as part of the facility's preventive maintenance program.</p> <p>D.</p> <p>(1) The Maintenance Director/designee will conduct weekly audits on all resident's room, to check for call bells adherence, the condition of doors their frames and ceiling tiles. Attachment 6 (2) The D.O.N./designee will conduct daily audits of all resident rooms to monitor that nebulizer tubing is off the floor(3) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/15

11/11/15
(2)

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F 253	Continued From page 18 tour.	F 253		11/11/15
F 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>F272</p> <p>A. (1) R89's MDS now reflects that he is edentulous. (2) R95 no longer resides at the facility. (3) R1 is now coded on her MDS for anticoagulant. (4) R65 no longer resides at the facility.</p> <p>B. (1) All residents have the potential to be affected by this deficient practice. (2) The RNAC/designee will audit all MDS's completed in the last 90 days to monitor that dental status, anticoagulants and that end of life are coded accurately. Changes to the MDS's will be made accordingly.</p>	11/11/15

11/14/15


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F 272	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record reviews, interviews and review of facility documentation, it was determined that for four (R1, R65, R89 and R95) out of 35 Stage 2 sampled residents, the facility failed to comprehensively assess and/or have a standardized reproducible assessment of each resident. For R89, the facility failed to accurately assess his dental status. For R1 the facility failed to accurately assess use of an anticoagulant. For R95, the facility failed to identify a terminal prognosis. For R65, the facility failed to ensure the accuracy of weights. Findings include:</p> <p>Review of the facility policy and guidelines entitled, "Resident Assessment/Minimum Data Set", last revised 1/2004, stated, "The facility will conduct initially and periodically a comprehensive, accurate, and standardized reproducible assessment of each resident's functional capacity...1. To provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status. The facility shall use resident observation and communication as a primary source of information when completing the RAI... 4. A Resident Assessment Instrument will be used to make a comprehensive assessment of a resident's needs and identify the resident's functional capacity and health status and includes...j. The resident's disease diagnosis and health conditions. k. The condition of the</p>	F 272	<p>C.</p> <p>(1) Now it will be the responsibility of nursing versus the dietitian to code the resident's dental status on the MDS. (2) The weight policy will be revised to have residents be weighed at the same time of day, in addition to having the staff note the type of scale used. The facility's previous policy and practice did not have the aforementioned distinctions. (3) The Staff Developer will educate C.N.A.'s and licensed nursing staff on the change in the facility's policy and practice. (4) Now on a weekly basis RNAC/designee will request a list from the pharmacy of all residents that are on anticoagulants. Anticoagulants will be coded appropriately from the list. (5) The facility has now placed the Hospice certifications in the resident's medical record for easier access for the RNAC to code end of life correctly. (6) The Staff Developer will educate the RNAC on the new location of Hospice certifications.</p>	11/14/15
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F 272	<p>Continued From page 20</p> <p>resident's teeth, gums, and other structures of the oral cavity. Need for dentures or other dental devices. I. The resident's nutritional status: weight..."</p> <p>1. Review of an ADL Self Care Performance Deficit Care Plan, initiated on 11/29/13, included an intervention for oral care and listed R89 with upper and lower dentures (false teeth).</p> <p>The significant change MDS assessment, dated 4/29/15, stated there were no dental/oral issues.</p> <p>R89 was observed without his dentures in place on 8/24/15 at 11:40 AM and on 8/27/15 at 7:30 AM and 8:00 AM.</p> <p>On 8/27/15 at 9:00 AM, R89 stated during an interview "I have no teeth." When asked about his dentures, he stated, "I don't like to wear them."</p> <p>An interview with E4 (RNAC) on 8/31/15 at 12:12 PM confirmed that the 4/29/15 significant change MDS assessment should have been marked as R 89 being edentulous.</p> <p>The facility failed to ensure the accuracy of the 4/29/15 significant change MDS assessment related to dental for R89.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 9/1/15 at 10:27 AM.</p> <p>2. R95's clinical record stated this resident was admitted to the facility under Hospice care for end stage liver disease.</p> <p>Review of the 5/5/15 admission MDS assessment</p>	F 272	<p>D.</p> <p>(1)Weekly the RNAC/designee will audit all MDS's that were completed regarding the accurately of coding of dental status, anticoagulants, and end of life. Attachment 7(2) The RD/designee will audit weights on a weekly basis for adherence to the facility policy regarding time of day, and type of scale used. Attachment 8 (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/15
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F 272	<p>Continued From page 21 revealed the facility failed to code R95 as having a condition or chronic disease that may result in a life expectancy of less than 6 months.</p> <p>Findings were confirmed with E1 during an interview on 9/1/15 at approximately 4:00 PM.</p> <p>3. Review of the July 2015 MAR revealed R1 received Xarelto from 7/15/15 through 7/21/15.</p> <p>The 7/21/15 significant change MDS assessment failed to code that R1 received an anticoagulant during the seven (7) days of the assessment review time period.</p> <p>Findings were confirmed by E1 and E2 during an interview on 9/1/15 at approximately 11:45 AM.</p> <p>4. R65 was re-admitted to the facility from the hospital on 5/16/15; she weighed 200 lbs. The admission weight was done using a mechanical lift. R65 was on a prescribed pureed diet with honey thick liquids.</p> <p>The admission MDS assessment, dated 5/23/15, listed R65's weight as 198 lbs. On 5/24/15, R65 weighed 168 lbs., reflecting a 30 lb. weight loss. R65's 14 day MDS assessment listed R65's weight as 179 lbs. R65 was not on a prescribed weight loss program.</p> <p>During an interview with E13 (RD) on 8/31/15 at approximately 12:30 PM, she stated that R65 was unable to provide her usual weight and she (E13) questioned the accuracy of the 5/6/15 weight (date prior to hospitalization) of 178.6 lbs.</p> <p>Weight review reflected inconsistency in the time of day weights were done, different types of</p>	F 272		11/11/15
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F 272	Continued From page 22 scales were used and reweighs were not consistently done when needed. These factors led to the 5/23/15 admission MDS inaccuracy.	F 272		11/11/15
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 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement.	F 278	A. (1) R20's MDS now reflects that the resident is receiving oral chemotherapy. B. (1) All residents that receive chemotherapy drugs have the potential to be affected by this deficient practice. (2) The RNAC/designee will audit the MDS's of all residents that receive oral chemotherapy drugs to monitor for accurate coding of the drug. Corrections will be made accordingly. C. Now on a weekly basis the RNAC/designee will request a list from the pharmacy of all residents that are on oral chemotherapy. Chemotherapy drugs will be coded appropriately from the list.	11/11/15

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F 278	Continued From page 23 This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to provide accurate MDS assessments that reflect the resident's status for one (R20) out of 35 stage 2 sampled residents. Findings include: Review of R20's 4/15/15 quarterly MDS, 5/4/15 significant change MDS and 6/23/15 significant change MDS revealed that R20 was receiving chemotherapy. Review of R20's 6/30/15 14 Day MDS incorrectly stated that the resident was not receiving chemotherapy. R20 continued to take oral chemotherapy from 6/24/15 through 6/30/15, during the 7 Day look back period. Findings were confirmed with E4 (RNAC) during an interview on 8/28/15 at approximately 2:45 PM	F 278	D. (1) Weekly the RNAC/designee will audit all MDS' that were completed during the time frame for accurate coding of chemotherapy drugs. Attachment 7. (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.	11/11/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on observation, record review, interview and review of other documentation, it was determined that for one (R68) out of 35 Stage 2 sampled residents, the facility failed to meet professional standards of quality, specifically all of the 8 rights of medication administration. R68's icy hot patch was signed off as removed from her	F 281	A. (1) R68's Icy Hot Patches was removed on 8/27/15 during the 7 to 3 shift. B. (1) All residents with medication patches have the potential it be affected by this deficient practice.	11/11/15	

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F 281	<p>Continued From page 24</p> <p>back on 8/26/15 at 8 PM on the MAR, however was observed to be still in place on R68's back the following morning. Findings include:</p> <p>According to Lippincott's Nursing 2012 Drug Handbook, the 8 rights of medication administration are as follows: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, and 8. Right response. (Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.)</p> <p>R68 was ordered to have an icy hot patch applied to her back for pain relief every day at 8 AM and removed every night at 8 PM.</p> <p>Review of R68's MAR revealed that the icy hot patch was signed off as having been removed on 8/26/15 at 8 PM.</p> <p>An observation during medication administration on 8/27/15 at 8:59 AM revealed that E10 (RN) removed the previous day's icy hot patch prior to applying the new patch.</p> <p>In an interview on 9/1/15 at 12:15 PM, E2 (DON) stated that the facility follows the standard of practice of the 8 rights of medication administration. Findings were immediately reviewed with E2. The facility failed to follow all of the 8 rights of medication administration when R 68's hot icy patch was not removed on 8/26/15 at 8 PM and the patch was signed off on the August 2015 MAR as removed.</p>	F 281	<p>C.</p> <p>(1) The Staff Developer will re-educate licensed nurses on the 8 rights of medication administration.</p> <p>(2) Now the facility will require that non narcotic medication patches be signed off by two nurses when they are removed. Narcotic patches already require a double signature of the two nurses.</p> <p>D.</p> <p>(1) The DON/designee will audit weekly all residents that have medication patches (narcotic & non narcotic) to monitor for a double nurse signature when they were removed. Attachment 9. (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/14	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 25</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review, review of hospital records and other documents as indicated, observation, and interview, 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 2 (R68 and R 121) out of 35 stage 2 sampled residents.</p> <p>R121 experienced a decline in condition between 12/23/14 and 1/2/15. During this time, there were multiple failures by the facility:</p> <ul style="list-style-type: none"> -Failure to obtain u/a and c/s ordered on both 12/23/14 and 12/24/14. -Failure on multiple occasions to notify the physician of changes in condition. -Failure to accurately and thoroughly assess the resident. -Failure to develop a care plan and identify interventions for use during this episodic period. <p>On 1/2/15 a physician order stated send resident to the ER. The BLS report of the same date stated R121 was found "unresponsive" with "hot, dry" skin. According to BLS, R121 had fevers for 4 days in the facility.</p> <p>The ER diagnosis included sepsis, respiratory</p>	F 309	<p>A.</p> <p>(1) R121 no longer resides at the facility. (2) R68's Icy Hot Patches was removed on 8/27/15 during the 7 to 3 shift.</p> <p>B.</p> <p>(1) All residents have the potential to be affected by this deficient practice. (2) All resident with medication patches have the potential to be affected by this deficient practice.</p>	<p>11/11/14</p>	

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F 309	<p>Continued From page 26</p> <p>failure, change in mental status, hypernatremia and dehydration.</p> <p>For R68, the facility failed to remove the resident's icy hot patch as per physician orders. Findings include:</p> <p>Review of an undated facility policy entitled "Transcribing Physician Orders", stated, "... All physician orders will be transcribed when they are received by a licensed nurse... Treatments will be transcribed on the TAR... Laboratory/Diagnostic Studies... will be... noted in the nursing progress notes (nurse's notes)...".</p> <p>The facility Notification of Condition Change: Physician policy, last revised in 11/2010, stated, "... nurses are responsible to provide timely and complete communication to physician's when there is a change in condition... Types of condition that may require notification of the physician: ... altered mental status... change in vital signs including temperature... pain... Document assessment data, attempted or actual correspondence with physician, and physician's response in the medical record...".</p> <p>1. R121, a 93 year old resident, was admitted to the facility in 2012. R121 received hospice services from approximately October 2013 until August 2014 when the resident broke her hip and the family wanted rehabilitative services.</p> <p>A quarterly MDS assessment, dated 11/21/14, coded R121 with severe cognitive impairment. She required extensive one staff person assistance with most ADLs, however, was able to</p>	F 309	<p>C.</p> <p>(1) The Interdisciplinary Team (IDT) which includes the Medical Director will review and revise the "Physician Notification of Condition" policy. Revisions will be made in accordance with AMDA's guidelines for identifying Acute Change in the Elderly. (2) The Staff Developer will educate the licensed nursing staff on the revised policy. (3) Now during morning meeting the IDT identifies residents on the 24 hour report that exhibit signs and symptoms that warrant physician notification. The team monitors that the physician was notified. If the policy was not followed the physician will be notified accordingly. (4) The facility devised a new tracking spreadsheet to better track the timeliness of U/A and C/S's collection. (5) The has implemented the need for nurses to assess and document resident's lungs status prior to the before initiation of PRN oxygen. The physician will be notified accordingly. (6) Now the facility will require that non narcotic medication patches be signed off by two nurses when they are removed. Narcotic patches already require a double signature of the two nurses.</p>	11/1/15	

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F 309	<p>Continued From page 27</p> <p>feed herself with supervision after set up help. R 121 was not on any special treatment, including hospice.</p> <p>Review of R121's care plan for swelling of her legs/feet, dated 7/11/14, listed interventions including "... Monitor vital signs as ordered and record. Notify MD of significant abnormalities... Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated...".</p> <p>Review of R121's care plan, dated 8/14/14, for the problem SOB related to musculoskeletal impairment listed a goal for R121's pulse oximetry (PO2) to remain above 92%. The January 2015 POS included an order, dated 8/14/14, to titrate R121's oxygen at 2L/min (liters per minute) via nasal cannula every shift to maintain PO2 > 92% as needed.</p> <p>The facility developed a care plan for potential for pain R/T R121's hip fracture and surgery to repair the broken hip, dated 10/31/14. Interventions included "Administer analgesia as per orders... Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain...".</p> <p>Record review revealed the following:</p> <p>NN on 12/5/14 and 12/6/14 recorded resident's RR, PO2 and T all within normal limits.</p> <p>There was no documented use of O2 use in the NN's from 12/5/14 through 12/16/14.</p> <p>12/17/14 NN (10:43 PM)- coughing, lungs clear and Robitussin ordered to be given every 6 hours</p>	F 309	<p>D.</p> <p>(1) The DON/designee will conduct daily audits of all 24 hour reports to monitor that the physician was notified as per policy. Attachment 1</p> <p>(2) The DON/designee will monitor that all U/A and C/S's ordered were obtained within 24 hours. If the urine was not obtained within 24 hours was the physician notified. Attachment 10. (3) Weekly the DON/designee will audit the TAR's on all residents that have PRN oxygen orders to monitor if the order was activated. If the order was activated was a lung assessment completed and documented. Additionally, was physician when notified when warranted. Attachment 10. (4) The DON/designee will audit weekly all residents that have medication patches (narcotic & non narcotic) to monitor for a double nurse signature when they were removed. Attachment 9. (5) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/15	

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F 309	<p>Continued From page 28 as needed for cough. RR 19, T 97.3 F.</p> <p>12/20/14 NN (2:49 PM)- no cough noted. Lungs sound clear. T 96.6 F.</p> <p>12/20/14 NN (9:44 PM)- no cough. T 98.0 F.</p> <p>There were no NN's for 12/21/14.</p> <p>12/22/14 NN (2:45 PM)- diet upgraded.</p> <p>12/23/14 physician progress note (12:20 PM)- "... doesn't look well... Feels tired... Mild chills... (lungs) CTA... Malaise r/o UTI... (check) UA & C/S (check) CXR ? cold will F/U."</p> <p>12/23/14 physician orders (12:30 PM)- "CXR... dx (diagnosis) SOB, R/O PNA, Urine for UA C/S" via telephone by E20 (MD).</p> <p>12/23/14 NN (12:57 PM)- new orders for CXR for SOB and u/a and c/s. Lung sounds diminished. C/O not feeling well. RR 16, T 97.8 F.</p> <p>12/23/14 NN (2:33 PM)- CXR done, result pending. U/A C/S specimen to be collected. In coming staff will be made aware.</p> <p>12/23/14 NN (11:47 PM)- alert and verbally responsive. Cold symptoms persist- medicated with Robitussin for cough. CXR negative for PNA. RR 22, T 98.6 F.</p> <p>12/24/14 NN (8:12 AM)- alert and verbally responsive. Cold symptoms persist. Robitussin given for dry cough. RR 22, T 100.7 F- Tylenol 650 mg given for elevated T.</p> <p>There was no evidence in the clinical record that</p>	F 309		11/11/15	

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(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 309	<p>Continued From page 29</p> <p>facility staff notified the MD of R121's elevated T.</p> <p>MAR review revealed that R121 received prn Tylenol at 5:45 AM on 12/24/14. R121 was due for routinely given Tylenol 650 mg. at 6 AM (she also receives routine Tylenol at 9 PM daily). According to the MAR, the 5:45 AM and 6 AM doses were signed off as given. The only other prn Tylenol given in December 2014 was on 12/23 for a headache.</p> <p>12/24/14 TAR (untimed)- 12/23/14 order for urine for UA C/S present. Note written onto back of TAR on 12/24/14 stating unable to collect urine on 7-3 and 3-11 shifts due to urinary incontinence</p> <p>12/24/14 physician progress note (untimed)- "... sick visit... called to review chest xray results (-)... R/O infection... await UA & C/S appears to be viral... (no) evidence pneumonia." R121 was seen by E9 (Medical Director).</p> <p>12/24/14 physician orders (untimed)- "ok to straight cath for UA & C/S" written by E9 .</p> <p>12/25/14 NN (3:05 AM)- alert and responsive. Episode of SOB with PO2 85%, prn O2 at 2L/min. with PO2 96%. No coughing. RR 20, T 98.0 F.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's abnormally low PO2 despite having ongoing supplemental O2 in place.</p> <p>12/25/14 NN (1:55 PM)- lethargic this shift, napping throughout shift. Dry cough- Robitussin given and effective. PO2 99% on room air (without supplemental O2). C/O severe pain all</p>	F 309		11/11/15	

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F 309	<p>Continued From page 30</p> <p>over- medicated per order with positive (+) results . No s/s (signs/symptoms) of distress/SOB. T 96.8 F.</p> <p>MAR review revealed that R121 was medicated with Oxycodone IR for generalized pain, 8/10 (0 being no pain and 10 being the worst) on 12/25/14 at 9 AM. R121's pain went down to 0 after being medicated. This was the only prn Oxycodone IR given in December 2014.</p> <p>The facility failed to notify the MD as per the 10/31/14 pain care plan to "Administer analgesia as per orders... Notify physician if... current complaint is a significant change from resident's past experience of pain...".</p> <p>12/26/14 NN (4:34 AM)- alert and responsive. No distress. RR 20, PO2 95% on O2 at 2L/min., T 99.4 F.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's elevated T or ongoing need for supplemental O2.</p> <p>12/26/14 NN (11:56 AM)- alert and responsive. Tolerated medications and meals. No coughing. PO2 94% on 2L/min O2, T 98.6 F.</p> <p>12/27/14 NN (12:46 AM)- alert and verbally responsive. Cold symptoms persist. RR 22, O2 at 2 L/min. T 100.5 F. Given Tylenol at 5 PM for elevated T (not documented on the MAR)- repeat T 99.0 F.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's elevated T or ongoing need for supplemental O2.</p>	F 309		11/11/15	

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F 309	<p>Continued From page 31</p> <p>12/27/14 NN (4:35 AM)- alert and verbally responsive. Rested well. RR 20, O2 on at 2L/min. with PO2 96%, T 99.8 F.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's elevated T or ongoing need for supplemental O2.</p> <p>12/27/14 NN (1:39 PM)- cold symptoms noted. RR 22, continues on O2 at 2L/min. PO2 95%, T 98.1 F.</p> <p>12/27/14 NN (9:39 PM)- alert and resting. Fluids encouraged and continue O2 at 2L/min. No SOB noted. T 96.8 F.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's ongoing need for supplemental O2. Additionally, despite R 121's decline and the facility stating they were monitoring for URI symptoms, review of NN's from 12/24/14 to 12/27/14 lacked complete lung assessments by nursing, including listening for breath sounds and any abnormal sounds.</p> <p>12/28/14 NN (7:19 AM)- alert and verbally responsive. Cold symptoms persist. No distress noted. RR 18, PO2 91% on 2L/min, T 98.4 F.</p> <p>There was no evidence that the facility increased R121's O2 to maintain her PO2 at 92% or > as per physician order or that they notified the MD of R121's decline in PO2.</p> <p>12/28/14 NN (7:31 AM)- new order to straight cath for U/A and C/S.</p> <p>12/28/14 NN (3:15 PM)- urine collected. Denies any pain. Fair appetite. Fluids encouraged. Lung</p>	F 309		11/11/15
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F 309	<p>Continued From page 32 sounds clear. PO2 94% (did not state if on O2), T 96.5 F.</p> <p>12/28/14 NN (10:21 PM)- U/A and C/S pending, no c/o discomfort while urinating, urine clear yellow without foul odor. T 96.3 F.</p> <p>12/28/14 U/A result (untimed)- urine amber and cloudy (as opposed to previous NN in which urine was noted to be clear yellow) with many bacteria. Note on UA result that E9 (Medical Director) aware and he will wait for c/s results- dated 12/29 /14 at 2:30 PM.</p> <p>12/29/14 NN (3:08 AM)- alert and responsive. No pain, SOB, or distress. No cough. RR 18, remains on O2 at 2L/min with PO2 94%, T 98.0 F</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's ongoing need for supplemental O2.</p> <p>12/29/14 NN (2:01 PM)- alert and verbally responsive. Assisted with feeding. Fluids encouraged. Total care by staff. Out of bed to wheel chair sitting by nurse's station. U/A and C/S pending. RR 20, O2 at 2 L/min with PO2 96%.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's ongoing need for supplemental O2 and that R121 has declined in ADLs now needing total care and having to be assisted with feeding.</p> <p>12/29/14 NN (2:17 PM)- High Risk Meeting held with E9 (Medical Director), E2 (DON), E1 (NHA) and E19 (RN). E9 wants to wait for urine c/s</p>	F 309		11/11/15
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F 309	<p>Continued From page 33 results as U/A results inconclusive.</p> <p>Although a high risk meeting was held in which R 121 was discussed, there was no evidence that R 121 was physically seen or examined by an MD on this date. There were no progress notes written since 12/24/14, although R121 continued to decline.</p> <p>12/29/14 NN (8:27 PM)- cold symptoms persist. RR 18, PO2 94%, T 98.6 F.</p> <p>12/30/14 NN (5:15 AM)- alert and verbally responsive. Cold symptoms persist. Urine c/s results pending. RR 20, T 99.3.</p> <p>There was no evidence in the clinical record that facility staff notified the MD of R121's ongoing need for supplemental O2 or elevated T.</p> <p>12/30/14 NN (1:50 PM)- urine C/S pending. Urine yellow, no pain or foul odor. Lethargic with poor appetite- refused lunch. No respiratory distress. T 97.2.</p> <p>12/30/14 NN (10:53 PM)- Urine C/S results pending. Will contact lab. No concerns this shift.</p> <p>12/30/14 NN (11:20 PM)- No cough, SOB, cold symptoms, or distress noted.</p> <p>12/31/14 NN (8:05 AM)- Cold symptoms persist. + general malaise. RR 18, O2 at 2 L/min with PO 2 93%, T 99.1 F.</p> <p>12/31/14 physician progress notes (12:36 PM)- called by nursing to review urine culture results. In no distress. Lungs clear. Urine c/s + for E. coli > 100,000+ colonies (of bacteria). UTI,</p>	F 309		11/11/15
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F 309	<p>Continued From page 34</p> <p>Augmentin (ABT) ordered twice a day for 7 days, may thicken (to make it easier to swallow). R121 was seen by E22 (MD).</p> <p>12/31/14 physician orders (12:36 PM)- Augmentin (as above) for UTI was written by E22 (MD) at 12:36 PM.</p> <p>12/31/14 physician orders (1:46 PM)- okay to give Amoxicillin/Clavpot (ABT) 500 mg/125 mg tablet by mouth now. Obtained telephone order from E22 at 1:46 PM.</p> <p>12/31/14 NN (5:52 PM)- monitoring for cold symptoms- has runny nose. No C/O pain. No SOB. Poor intake today. Fluids encouraged and tolerated. Started Augmentin for UTI. Nasal O2 on at 2-3 L/min. with PO2 94%. T 97.7 F.</p> <p>12/31/14 NN (9:41 PM)- Started new ABT for UTI. Poor appetite this shift, fluids encouraged. PO2 93%, T 97.9 F.</p> <p>1/1/15 NN (6:23 AM)- Cold symptoms persist, but remains stable resting in bed. Poor oral intake. Started on Augmentin for UTI. RR 16, PO2 94 %, T 97.6 F.</p> <p>1/1/15 NN (4:20 PM)- RR 22, PO2 76-80% on O2 at 3 L/min. T 100.7 F. Obtained telephone orders for STAT CBC, BMP (laboratory tests) and CXR from E23 (NP) at approximately 12:00 PM.</p> <p>Review of the 1/1/15 lab results revealed a critical sodium of 155 (135-145), chloride high at 110 (98-107), BUN high at 44 (8-23), creatinine high at 1.8 ((0.6- 1.5), and glucose high at 196 (74-106). WBC count high at 24,000 (3,500- 11,000) indicative of an infection.</p>	F 309		11/11/15	

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F 309	<p>Continued From page 35</p> <p>1/1/15 NN (11:37 PM)- CXR shows pneumonia in both lower lobes- new telephone order obtained by E20 (MD) at approximately 5:50 PM for Doxycycline (ABT) twice a day for 7 days. CBC and BMP abnormal with no new orders. Fluids provided and tolerated well. RR 20, T 99.8 F.</p> <p>1/2/15 NN (3:15 AM)- alert and verbally responsive. T 100.6 F- prn Tylenol given for elevated T.</p> <p>1/2/15 NN (7:58 AM)- T 101.3 F (still febrile despite being on ABT's)- prn Tylenol given for elevated T at 5:30 AM. PO2 90-91% on O2 at 3 L/min. via nasal cannula. Oral fluids encouraged, but not taken well.</p> <p>1/2/15 physician orders (10:55 AM)- send to ER for evaluation due to PO2 81% on O2.</p> <p>1/2/15 NN (12:32 PM)- sent to ER due to PO2 81% on O2 at 2 L/min. + labored breathing with use of abdominal muscles. RR 22, T 100.2 F.</p> <p>Review of NN's from 12/29/14 to 1/2/15 lacked complete lung assessments by nursing, including listening for breath sounds and any abnormal sounds.</p> <p>The BLS report, dated 1/2/15, stated the ambulance crew was notified at 10:59 AM and they reached R121 at 11:05 AM. R121 was found "unresponsive" with "hot, dry" skin. BLS immediately applied oxygen at 15 L/min. via a non-rebreather mask (NRB) and after 5 minutes, R121's PO2 increased to 88% and her RR was 36. According to BLS, R121 had fevers for 4 days in the facility.</p>	F 309		11/11/15

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F 309	Continued From page 36 Review of the ALS- medics report, dated 1/2/15, revealed that ALS met the BLS ambulance at 11:13 AM. BLS reported that R121 found in facility with increased respiratory rate with a PO2 of 79% and change in mental status. Family reported to BLS they noticed changes in resident condition this morning and asked staff to summon 911 (R121 was a DNR). ALS started an IV to administer fluids and monitored R121's heart rhythm and vital signs until they released the resident to the ER at 11:30 AM. During ALS care, R121 opened her eyes and withdrew in response to painful stimuli and she continued to have labored breathing with abnormal breath sounds and a PO 2 87-89% on oxygen via NRB as above. R121's RR ranged from 36-40 on a NRB mask at 15 L/min. during the time ALS provided care. Review of hospital ER records, dated 1/2/15 and timed 11:49 AM, stated that R121 presented to the ER with severe SOB, not worsened or alleviated by anything. R121 had URI with cough for about 2 weeks and few days ago was diagnosed with UTI and started on Augmentin. Was diagnosed with PNA yesterday and started on Doxycycline. Has had steady decline in health for past few weeks, acutely worse today. PO2 89% on 15 L/min. NRB + severe respiratory distress, transitioned to BiPAP and PO2 improved to 93-95%. Family does not want resident to be intubated or CPR, they want her to be comfortable and are okay with antibiotics and fluids at this time and to see how she does on a trial of BiPAP. Laboratory reports upon admission to the ER revealed severe dehydration, AKI, and hypernatremia. R121's WBC count in the ER was	F 309		11/11/15	

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F 309	<p>Continued From page 37</p> <p>very high at 26,500 (3,500- 11,000), indicating infection. R121's sodium was critically high 163 (136-146), BUN high at 58 (8-22) and Creatinine 1.90 (0.50- 1.00) indicative of dehydration and ARF</p> <p>The facility developed a care plan "... is on Antibiotic Therapy for PNA and UTI" on 1/2/15, the day R121 was sent to the ER and admitted to the hospital. Interventions included, "... Report pertinent lab results to MD (dated 5/14/14, although care plan developed on 1/2/15). Although R121 showed a decline with URI symptoms for 2 weeks, the facility failed to develop a care plan with interventions for it.</p> <p>The hospital Discharge Summary, dated 1/14/15, listed diagnoses of aspiration pneumonia, sepsis, ARF, respiratory failure secondary to above.</p> <p>A Doctor's Order Sheet Certification Of Medical Necessity For Transport By Ambulance, dated 1/14/15, stated that R121 was being transferred to a hospice unit in another hospital d/t "... nonresponsive/catatonic... end stage dementia ...".</p> <p>R121's death certificate listed the immediate cause of death as sepsis followed by aspiration pneumonia. Date of death was 1/16/15.</p> <p>An interview was done with E9 (Medical Director) on 8/31/15 at 3:04 PM. E9 stated he recalled this case somewhat. Reviewed u/a and c/s ordered on 12/23/14 and on 12/24/14 a physician order was written to straight cath for urine tests if needed. R121 with elevated temperatures, decreased appetite and lethargic. Another physician order was written on 12/28/14 for u/a and c/s as urine not obtained from 12/23/14 or 12</p>	F 309		11/11/15	

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F 309	<p>Continued From page 38</p> <p>infection. R121's sodium was critically high 163 (136-146), BUN high at 58 (8-22) and Creatinine 1.90 (0.50- 1.00) indicative of dehydration and ARF.</p> <p>The facility developed a care plan "... is on Antibiotic Therapy for PNA and UTI" on 1/2/15, the day R121 was sent to the ER and admitted to the hospital. Interventions included, "... Report pertinent lab results to MD (dated 5/14/14, although care plan developed on 1/2/15), Although R121 showed a decline with URI symptoms for 2 weeks, the facility failed to develop a care plan with interventions for it.</p> <p>The hospital Discharge Summary, dated 1/14/15, listed diagnoses of aspiration pneumonia, sepsis, ARF, respiratory failure secondary to above.</p> <p>A Doctor's Order Sheet Certification Of Medical Necessity For Transport By Ambulance, dated 1/14/15, stated that R121 was being transferred to a hospice unit in another hospital d/t "... nonresponsive/catatonic... end stage dementia...".</p> <p>R121's death certificate listed the immediate cause of death as sepsis followed by aspiration pneumonia. Date of death was 1/16/15.</p> <p>An interview was done with E9 (Medical Director) on 8/31/15 at 3:04 PM. E9 stated he recalled this case somewhat. Reviewed u/a and c/s ordered on 12/23/14 and on 12/24/14 a physician order was written to straight cath for urine tests if needed. R121 with elevated temperatures, decreased appetite and lethargic. Another physician order was written on 12/28/14 for u/a and c/s as urine not obtained from 12/23/14 or 12/24/14 physician orders. E9 stated he was not</p>	F 309		11/11/15
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F 309	<p>Continued From page 38</p> <p>/24/14 physician orders. E9 stated he was not the primary care physician for R121, but he would expect if he orders something for it to be done.</p> <p>Findings were reviewed with E1 and E2 during an interview on 9/1/15 at approximately 3 PM.</p> <p>2. R68 was ordered to have an Icy Hot Patch applied to her back for pain relief every day at 8 AM and removed every night at 8 PM.</p> <p>Review of R68's August 2015 MAR revealed that the 8 PM removal of the icy hot patch for R68 was signed off as completed on 8/26/15.</p> <p>An observation during medication administration on 8/27/15 at 8:59 AM revealed that E10 (RN) removed the previous day's icy hot patch prior to applying the new patch.</p> <p>In an interview on 8/27/15 at approximately 2:30 PM, E10 confirmed that the icy hot patch she removed should have been removed on 8/26/15 at 8 PM. The facility failed to follow physician orders where R68's icy hot patch was not removed on 8/26/15 at 8 PM.</p>	F 309		11/11/15
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 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed</p>	F 332	<p>A.</p> <p>(1) The nurse was educated on the correct way to dose Spiriva. (2) The nurse was educated on the need to wait 1 minute between different inhaled medications when administering Advair.</p>	

11/14/15


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F 332	<p>Continued From page 39</p> <p>to ensure that it was free of medication error rates of 5% or greater during the medication pass observation. On 8/27/15, there were two (2) medication errors observed out of 25 opportunities, an 8% error rate during medication pass observation. Findings include:</p> <p>1. An observation during the medication pass on 8/27/15 at 8:28 AM revealed that R90 inhaled Spiriva, a breathing medication, only one time.</p> <p>Review of R90's Spiriva medication label stated that he was ordered to inhale the contents of 1 capsule. Additional instructions on the Spiriva medication label stated to inhale 2 times per 1 capsule.</p> <p>2. An observation during the medication pass on 8/27/15 at 8:28 AM revealed that R90 was administered a second breathing medication (Advair) by inhalation.</p> <p>R90's pharmacy medication label instructions for Advair stated, "Medication has boxed warning. Wait at least 1 minute between different inhaled medications ...".</p> <p>On observation, E12 (RN) did not time the interval between the administration of the Advair inhalation and the administration of the Spiriva inhalation to ensure that one minute passed between the administrations of two different inhalation medications.</p> <p>In an interview on 8/27/15 at approx. 2:35 PM, findings were reviewed with E12 (RN).</p> <p>Findings were also reviewed with E2 (DON) on 9/1/15 at 12:30 PM. The facility failed to administer</p>	F 332	<p>B. All residents that receive inhaled medications have the potential to be affected by this deficient practice.</p> <p>C. (1) The Staff Developer will develop an educational module specifically on inhaled medications to include meter dose inhaler administration to include a timing mechanism. (2) The new module will now be included in the facility's New Hire Orientation for nurses. (3) The Staff Developer will also educate the licensed nurses on the inhaled medication module.</p> <p>D. (1) The Staff Developer/designee will conduct weekly audits of twenty percent of licensed nurse administering inhaled medications for accuracy. Attachment 11. (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/11/15

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F 332	Continued From page 40 the correct dose of Spiriva medication to R90 when he was observed inhaling only one time despite the order to inhale two times. The facility failed to ensure that one minute passed between the administrations of two different inhalation medications for R90.	F 332		11/11/15
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --	F 334	A. (1)The facility cannot retroactively address the discrepancy regarding R33, R1, and R20's pneumo vaccine. (2) The facility cannot retroactively address the discrepancy regarding R71's flu vaccine.	11/11/15

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F 334	<p>Continued From page 41</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of other documentation as indicated and interview, it was determined that the facility failed to ensure that 2</p>	F 334	<p>B.</p> <p>(1) All residents have the potential to be affected by this deficient practice. (2) The Staff Developer/designee will check the status of all residents' pneumo vaccine. The audit will include monitoring for documentation of consent or refusals and proof of administration. When indicated the facility will provide education, consents and administer vaccines. When necessary the facility will document POA's verbal consent /refusal in the resident's medical record. Consents or refusals and proof of vaccine will be maintained on the resident's medical record. (3) Since flu shots are offered annually all residents will be offered a flu vaccine during the flu season with proper consent and documentation.</p>	11/11/15

(Signature)
11/4/15

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F 334	<p>Continued From page 42</p> <p>(R1 and R33) residents received pneumococcal (pneumo) vaccines after receiving consent, that 1 (R20) resident's pneumo vaccine status was determined, and that 1 (R71) resident out of 5 sampled had documented evidence of refusal or contraindication for influenza (flu) vaccine and there was no evidence that R71 received a flu vaccine for 2014. Findings include:</p> <p>Review of the facility Infection Control policy (undated) stated, "... facility shall document evidence of annual vaccination against influenza for each resident... Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year... Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident... document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older... unless... vaccination is medically contraindicated or... refuse... facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission...".</p> <p>Review of an Immunization Form, revised on 4/14 /09, included areas for documentation of the last known flu and pneumo vaccines and the facility where they were given. This form also stated flu vaccines are offered yearly unless contraindicated and for the pneumo vaccine to be offered annually if resident refuses and to update as ordered.</p> <p>Review of an undated Pneumococcal Vaccine Consent Form stated that a second dose was recommended for residents age 65 and older, if 5</p>	F 334	<p>C.</p> <p>(1) The facility has changed their system regarding new admissions. The facility will now only accept written not verbal confirmation that vaccine(s) were given. If written confirmation is not obtained the facility will offer the vaccine(s) accordingly. The facility will provide educational material and a consent/refusal form when offering the vaccine. Proof of administration and the consent/refusal form will stay on the resident's medical record. (2)During flu season the facility will offer annual consent/refusal forms and CDC education regarding the vaccine. Proof of administration and the consent/refusal form will stay on the resident's medical record. When necessary the facility will document POA's verbal consent /refusal in the resident's medical record.</p>	11/11/15	

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F 334	Continued From page 43 years have passed since that dose and is ...". 1. R33- Pneumo given July 2007. A consent for pneumo vaccine was obtained on 6/21/13, however, there was no evidence that the vaccine was administered. 2. R1- Pneumo given 2/3/03. A consent for pneumo vaccine was obtained on 3/15/12, however, there was no documentation that the vaccine was administered. 3. R71- Flu vaccine given 10/24/13. There was no signed refusal or documentation of contraindication(s) for R71 to receive the 2014 flu vaccine. Additionally, there was no evidence that R71 received the 2014 flu vaccine. 4. R20- There was no evidence that the facility obtained R20's pneumo status. Flu and pneumo vaccine information was sparse and not up to date in the clinical records. Advised E21 (Infection Control Nurse) during an interview on 8/27/15 at 12:05 PM and requested information needed. Interview with E21 on 8/28/15 at 11:30 AM confirmed that she was unable to locate any further documentation related to flu and pneumo vaccines for the above residents. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 9/1/15 at approximately 4:30 PM.	F 334	D. (1) The Staff Developer/designee will conduct weekly audits on new admissions for written proof of pneumo vaccine and flu (in season) administration. Attachment 12. (2) During flu season the Staff Developer/designee will conduct weekly audits on residents for consent or refusal along with proof of education and administration. Attachment 12. (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.	11/11/15	
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456	A. (1) The porcelain hand sink has been replaced with a Stainless Steele sink. (2) The two hand sinks in the food preparation area had splash guards installed.		

11/4/15
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F 456	Continued From page 44 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Findings include: 1. On 8/24/15 at 8:50 AM, the kitchen hand sink was observed to be made of porcelain. The sink had clearly visible scratch marks that were considered not easily cleanable. According to FDA hand washing sink specifications, a hand sink in food service areas must be constructed with easily cleanable material. Porcelain is no longer considered an acceptable construction material and could harbor microorganisms. 2. On 8/24/15 at 8:55 AM observation of two hand sinks in the food preparation area revealed lack of splash guards. Both hand sinks were approximately 3 inches away from the food preparation table. Splashing during hand washing could potentially contaminate the food contact surfaces. Both of the above findings were confirmed by E14 (FSD) during an interview on 8/24/15 at 9:10 AM. 483.75(j)(1) ADMINISTRATION	F 456	B. All residents have the potential to be affected by this deficient practice. C. Since the survey the Maintenance Director placed the hand sinks and splash guards into the facility's electronic preventive management system (TELS). Now maintenance will check hand sinks and splash guards monthly as part of the facility's preventive maintenance program. D. (1) The Maintenance Director/designee will conduct weekly audits of the condition of the hand sinks and splash guards in the kitchen. Attachment 13. (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.	11/11/15	
F 502 SS=D	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502	A. (1) R121 no longer resides at the facility.		

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11/4/15

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F 502	Continued From page 45 of the services. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that the facility failed to obtain laboratory services to meet the needs of one (R 121) out of 35 stage 2 sampled residents. The facility failed to obtain a u/a and c/s in a timely manner for R121; the specimen for the tests was obtained 5 days after it was ordered. Findings include: Cross refer to F309, example #1 R121 had a u/a and c/s ordered on 12/23/14. Another physician order was written on 12/24/14 to straight cath for u/a & c/s if needed. Nurse's notes stated there was a new physician's order on 12/28/14 to straight cath for a u/a and c/s (although no physician order written) and urine was collected on 12/28/14 for the u/a and c/s. The facility failed to obtain a u/a and c/s on R121 for 5 days. During the 5 day delay R121 experienced periods of lethargy, low grade fevers, poor appetite, and requiring O2. Findings were reviewed with E1 (NHA) and E2 (DON) during an interview on 9/1/15 at approximately 3 PM.	F 502	B. All residents that have a U/A and C/S ordered have the potential to be affected by this deficient practice. C. (1) The facility developed a new system for tracking U/A and C/S's. The tracking system will be reviewed in the daily morning meeting for timeliness of obtaining specimens and results (2) The Staff Developer will educate licensed nurses on the new tracking system. D. (1) The DON/designee will conduct weekly audits on all U/A and C/S's for timeliness of collection. Attachment 10 (2) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.	11/11/15	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514			

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F 514	<p>Continued From page 46</p> <p>accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for two (R89 and R121) out of 35 stage 2 sampled residents. For R89, the facility failed to have accurate documentation on the 4/2/15 Elopement Screen and the 7/16/15 Nutrition Assessment. For R121, the facility failed to have a complete interdisciplinary discharge summary. Findings include:</p> <p>The facility policy and guidelines entitled, "Assessments", last revised 11/2014, stated, "The following resident assessments will be completed on admission/readmission, quarterly, with significant change and as needed:...3. Elopement ...6. Nutrition... Assessments will be completed to ensure quality of care for all residents..."</p> <p>The facility policy and guidelines entitled, "Resident Assessment/Minimum Data Set", last revised 1/2004, stated, "Discharge Summary - 32 . When the facility anticipates discharge (sic.) a resident will have a discharge summary to ensure</p>	F 514	<p>A.</p> <p>(1) R89's elopement assessment now accurately reflects his history of wandering.</p> <p>(2) R89's nutrition assessment now accurately reflects his dental status.</p> <p>(3) The attending physician for R121 is no longer practicing at Regency thus corrections to the discharge</p> <p>B.</p> <p>(1) All residents have the potential to be affected by this potential practice. (2) The DON/designee will audit all elopement assessments of active residents completed in the last 90 days. Corrections will be made accordingly. (3) The Medical Records Clerk/designee will audit the discharge summary of all residents discharged from the facility within the last 30 days. Audits will monitor for the correct discharge date, pertinent physical and laboratory findings and course of treatment. Attending physician will be contacted accordingly to make necessary changes.</p> <p>(3) The Dietitian/designee will audit nutrition assessments completed of all active residents in the last 90 days for accuracy of dental status and will correct accordingly.</p>	11/11/15

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F 514	<p>Continued From page 47</p> <p>appropriate discharge planning and communication of necessary information to the continuing care provider. a. Recapitulate the resident's stay. b. A final summary of the resident's status...b. Address necessary post-discharge care...</p> <p>1a. Review of R89's care plan, dated 3/12/14 (last revised 4/8/15), stated that R89 had a potential for elopement and actual incident of elopement on 3/26/15.</p> <p>A nurse's note dated 3/26/15 at 4:19 PM stated that at around 1:35 PM R89 was accompanied to the facility's van, seated at the front seat with his seatbelt on. At 1:35 PM activity looked in the van and R89 was gone, R89 was then found at 2:28 PM.</p> <p>Review of the 4/2/15 Quarterly Elopement Screen, signed by E7 (UM), stated R89 had the following potential risk factors: elopement history; independently mobile; and wandering history. This same screen also stated that the resident had not exhibited any behavior of wandering and left blank the question that asked "Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?"</p> <p>The facility failed to ensure the accuracy of R89's history of wandering.</p> <p>An interview with E7 (UM) on 8/27/15 at 3:26 PM confirmed the findings.</p> <p>b. Review of an ADL Self Care Performance Deficit Care Plan initiated on 11/29/2013 included an intervention for oral care and listed R89 with</p>	F 514	<p>C.</p> <p>(1) The facility now requires the nurse completing elopement assessments to review the resident's incident reports for the previous 90 days prior to the assessment. (2) The Staff Developer will educate nurses on this change in system regarding elopement assessments (3) All physicians that have privileges at Regency will be contacted by NHA/designee regarding the need to write complete and accurate discharge summaries. Complete and accurate summaries include but are not limited to the correct discharge date, pertinent physical and laboratory findings and course of treatment (4) The Medical Record Clerk will now discuss the discharge summaries with the IDT during the morning meeting to determine if they are complete and accurate. Physicians will be contacted accordingly. (5) The facility will now require that the dietitian will confirm with nursing the dental status of the resident prior to completing nutritional assessments.</p>	11/10/15
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F 514	<p>Continued From page 48 upper and lower dentures (false teeth).</p> <p>The Nutrition Assessment, dated 7/6/15, stated there were no dental/oral issues.</p> <p>On the following dates R89 was observed without his dentures in place: - 8/24/15 at approximately 11:40 AM; - 8/27/15 at 7:30 AM; - 8/27/15 at 8:00 AM; - 8/27/15 at 9:00 AM, R89 was asked by the surveyor where his teeth were, he smiled and stated "I have no teeth." He was then asked about his dentures and he stated, " I don't like to wear them." -8/30/15 at 4:45 PM.</p> <p>An interview with E13 (RD) on 8/31/15 at 12:33 PM confirmed that the Nutrition Assessment dated 7/6/15 was incorrect and would make the correction.</p> <p>The facility failed to ensure the accuracy of the nutrition assessment related to dental for R89.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 9/1/15 at 10:27 AM.</p> <p>2. Review of R121's Interdisciplinary Discharge Summary incorrectly listed a discharge date of 1/9/15 when the resident was discharged to the hospital on 1/2/15 and did not return. Additionally, there were several areas that were not completed including: reason for admission, treatment provided, progress (including any complications), reason for discharge, sensory impairments, mental and psychosocial status, cognitive status, clinical laboratory values/ diagnostic tests, and other comments to include</p>	F 514	<p>D.</p> <p>(1) The DON/designee will audit elopement assessments weekly for accuracy. Attachment 14. (2) The Medical Record Clerk/designee will conduct weekly audits of all discharge summaries completed that week. The Discharge Summary is to include but not limited to the correct discharge date, pertinent physical and laboratory findings and course of treatment. Attachment 3. (3) The DON/designee will audit the accuracy of the resident's dental status on all nutrition assessment completed that week. Attachment 14 (4) The compliance rate of the weekly audits will be reported in monthly QA&A until 100% compliance is achieved.</p>	11/1/15	

Dr
11/4/15

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

PRINTED: 11/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HEALTHCARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 49 why R121 was sent to the hospital.</p> <p>Findings were reviewed with E1 and E2 during an interview on 9/1/15 at approximately 3 PM.</p> <p>The facility failed to have an accurate and complete Interdisciplinary Discharge Summary for R121.</p>	F 514		<p>11/1/15</p> <p>_____</p>

11/4/15
[Signature]



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare & Rehab Center

DATE SURVEY COMPLETED: September 1, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>Revised report following Informal Dispute Resolution held on October 27, 2015. F279 was deleted. Text changes made to F332. F309 unchanged.</p> <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from August 24, 2015 through September 1, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 92. The Stage 2 survey sample size was 35.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p>		
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Provider's Signature Laura M. Sieren Title NHA Date 11/4/15



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	<p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed Cross Refer to the CMS 2567-L survey completed September 1, 2015 -- F157, F159, F202, F225, F246, F253, F272, F278, F281, F309, F332, F334, F456, F502, and F514.</p>	<p>Cross Refer to the Plan of Correction for CMS 2567-L survey completed September 1, 2015 -- F157, F159, F202, F225, F246, F253, F272, F278, F281, F309, F332, F334, F456, F502, and F514.</p>	

Provider's Signature Debra M. Stein Title NHA Date 11/4/15